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ABSTRACT

An exploratory study was conducted to examine the ways in which existing programs or service delivery systems have adapted to meet the needs of homeless families with children. Key issues and model and innovative approaches were identified prior to study site visits in five cities: (1) Atlanta (Georgia); (2) Baltimore (Maryland); (3) Boston (Massachusetts); (4) Minneapolis (Minnesota); and (5) Oakland (California). This volume begins with an overview of the problem of family homelessness based on the literature review and the discussions that preceded the site visits. The core of this volume is the presentation of cross-site findings from the five cities, including discussions of the issues and barriers discovered during the visits. It was apparent that unless income increases, or rent decreases, poor families will be at-risk of repeated episodes of homelessness. Building self-sufficiency is the long-term solution. It is also apparent that the homeless service system is only as effective as the mainstream services to which the family is linked. Fragmented and duplicated services and lack of follow-up reduce the efficiency of the programs now in place and impede the development of better means of support. Three tables and four exhibits illustrate the discussion, and two appendixes present information about study methodology. (SLD)

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ED 385 669

HOMELESS FAMILIES WITH CHILDREN: PROGRAMMATIC RESPONSES OF FIVE COMMUNITIES

VOLUME I
CROSS-SITE COMPARISONS AND FINDINGS

CONTRACT # HHS-100-87-0039-10

Submitted to:

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Table of Contents

Page

Volume I. Cross-Site Comparisons and Findings

Acknowledgements

Executive Summary iv

I. Introduction and Purpose 1

II. Overview of the Problem 3

III. Study Methodology 28

IV. The Context of Homeless Services 34

V. Cross-Site Findings: Coordination of Services 45

VI. Cross-Site Findings: Comprehensiveness of Services 55

VII. Policy and Program Issues and Barriers 82

Appendices

A. Participants in Telephone Discussions and Site Visit Interviews

B. Discussion Guides for Telephone Discussions and Site Visit Interviews

Volume II. Site Visit Reports and Program Profiles

Acknowledgements

Executive Summary iv

I. Atlanta 1

II. Baltimore 54

III. Boston 96

Table of Contents, Continued

Page

IV. Minneapolis 138

V. Oakland 193

Appendix

A. Glossary of Terms

Acknowledgements

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The study team is also indebted to the many energetic and dedicated people serving homeless families with children who were willing to share their experiences with us. Many of these individuals had tremendous responsibilities and overwhelming workloads; that they took time to share information with Macro was greatly appreciated.

Macro study team members and authors of this report are Lela Baughman, Thomas Chapel (project manager), and Carolyn Rutsch. Martin Kotler also contributed to this study.

Executive Summary

I. Introduction

In July 1990, Macro Systems, Inc., under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (DHHS), was commissioned to undertake an exploratory study of the service system for homeless families with children.

It is widely believed that throughout the country a fairly large number of programs exist to respond to the needs of homeless families; one purpose of this project was to facilitate community-based efforts by identifying and describing particularly promising programs and practices and analyzing the roles of various levels of government and of the voluntary sector in providing services. The study objectives included the following:

- Describe the specialized needs of homeless families, and provide insights into the prevalence of this population and factors contributing to family homelessness.
- Identify five program configurations designed to meet the needs of this population that are widely regarded as model approaches.
- Examine these program configurations in-depth.
- Identify policy issues and barriers affecting programs for homeless families.

The study was intended as an exploratory study to examine the ways in which existing programs or service delivery systems have adapted to meet the needs of homeless families with children. Through a comprehensive literature review, telephone discussions with national experts who are familiar with issues and programs serving homeless families with children, and telephone discussions with providers, advocates, and agency officials in selected cities that are experiencing a significant problem with family homelessness, the study team identified the key issues, model and innovative approaches, and made preliminary selections of cities for in-depth site visits.

The study team conducted case study site visits in five cities: Atlanta, Georgia; Baltimore, Maryland; Boston, Massachusetts; Minneapolis, Minnesota; and Oakland, California. In each city, the team identified for interviews those programs and agency contacts who could best provide a comprehensive picture of the service delivery system for homeless families with children. The findings of the site visits were used to identify policy and service delivery issues related to meeting the needs of homeless families.

This final report is in two volumes. Volume I begins with an overview of the problem of family homelessness based on a review of the literature and discussions with national experts and prominent service providers, advocates, and public officials in major U.S. cities. The core of the first volume is the presentation of cross-site findings from the five site visits.

These findings are grouped into two categories: findings related to coordination of services and findings related to comprehensiveness of services. The final chapter of Volume I discusses issues and barriers that were discovered during the site visits. These are program and policy concerns that have influenced the state of homeless services in the past and will shape the options for the future.

Volume II of the final report includes the site visit reports for each of the five cities and the profiles of the programs visited in each city.

II. Cross-Site Findings

In examining the service system for homeless families in five diverse cities, the site visit team found themes and patterns in the provision of services and the larger context within which programs operate. Two categories of findings emerged from the site visits: coordination of services refers to the degree to which the elements of the service system are integrated or planned at the public agency, service provider, and/or participant level; comprehensiveness of services is the degree to which the service system includes the broad array of services that homeless families might need and provides these services in a way that makes them most accessible by homeless families.

Six findings related to coordination of services emerged from the site visits. They include the following:

- At the public agency level, there is very little coordination among agencies in dealing with the problems of homeless families.
- At the service provider level, every city has one or more coordinating mechanisms such as a coalition or task force. Although public agencies may participate actively in these, the coalitions are usually provider- or advocate-driven.
- Although cities offer many sources of information and referral to services, there is very little integrated delivery of services through mechanisms such as one-stop shopping.
- Coordinated and comprehensive services planning, such as case management, is a major gap in the service system for homeless families. The case management that does occur is usually provided by service programs as an adjunct to their regular services.
- Lack of followup of homeless families once they leave the service system is a major problem. Even though followup can help ensure that families are stably linked to services, many homeless families do not want to be followed once they leave the service system.
- Outcome evaluation of programs for homeless families is rarely done and would be difficult to accomplish because of uncertainty about program goals and inability to track outcomes or attribute successes to program efforts.

Besides the findings on coordination of services, the following 13 findings emerged from the five sites concerning the comprehensiveness of the service delivery system. These include the following:

- Although housing services are often conceptualized as a continuum, the cities visited do not have a true housing continuum in place that includes emergency shelter, transitional housing, and services-enriched permanent housing. Usually one or more of the components of the continuum are either missing or suffer from inadequate capacity to meet the demand.

- Even when the components of the continuum are in place, the links between the various components are often either weak or nonexistent. As a result, homeless families are often left to navigate the system on their own and may not receive the amount and degree of services they need to move through the continuum successfully.

- Support services for homeless families are often provided in an inappropriate setting within the housing continuum. In particular, services are often concentrated in emergency shelter even though families may remain for only a brief time and their immediate crisis makes them less receptive to services aimed at long-term needs such as employability or personal problems.

- Health care is the service most commonly provided by programs set up specifically to serve homeless individuals and families. Separate programs are often needed because operational characteristics and lack of capacity in mainstream health care services renders them inaccessible to homeless families.

- The McKinney Act education provisions have greatly improved homeless school-age children's access to the public school system and to the school that is in the best interest of the student, mainly because the cities visited have voluntarily chosen to provide transportation to schools.

- Preschool programs, including Head Start, are not serving the majority of homeless preschool-age children because of lack of capacity and because hours of operation and program performance incentives regarding attendance and followup tend to exclude homeless children.

- Links to employment and training programs are weak; adult members of homeless families rarely benefit from these programs. Many are unskilled and may have multiple problems, but current funding is not flexible enough to address their multiple needs and program performance incentives regarding job placements tend to discourage programs from serving homeless adults.

- Lack of adequate child care once families leave the homeless service system is one of the most frequently cited obstacles to independent living for homeless families.

- Child protective services does not remove children from their families for homelessness alone. However, the parents' homelessness does make it difficult to reunite families that have been separated for other reasons.

- Eligibility screening and application assistance for WIC and for major entitlement programs such as AFDC, Medical Assistance, and food stamps, is routinely being provided to homeless families by a variety of homeless service providers.

- Demand exceeds supply for almost all types of substance abuse treatment to which low-income people have access. The problem is especially severe for homeless mothers with children; very few residential treatment programs are able to accommodate children of mothers in treatment.

- Battered women are often counted as part of the homeless family caseload, but the domestic violence system and homeless service system are separate and the links between the two systems are not strong or visible. In many of the cities visited, the homeless shelter system often receives the overflow from an overburdened domestic violence shelter system.

III. Policy and Program Issues and Barriers

Based on the observations of the site visit team and the comments of providers, advocates, officials, and experts in the five cities visited, the following policy and program issues and barriers emerged from the site visits:

- Unless incomes go up or rents go down, poor families will be at-risk of repeated episodes of homelessness.

  Measures which act to raise incomes of the poorest of poor families or increase the availability of affordable housing attack homelessness at its roots. While AFDC benefits and housing subsidies are necessary, they are shorter term palliatives; building self-sufficiency is the longer term solution. Actions which will help raise incomes, lower barriers to higher paying jobs, or lower rents include the following:

  - Emphasize education and skills training which will improve the access of families to higher-paying jobs.

  - Use the homeless service system as a case-finding opportunity for targeted employment and training programs.

  - Extend subsidized child care for homeless women into their period of permanent housing.

  - Encourage Federal preferences for homeless families in making assignments to public and subsidized housing.

  - Encourage flexibility in use of funds for move-in assistance such as first and last months' rent, security deposits, or rent arrearages.

- In the long run, the homeless services system is only as effective as the mainstream services to which homeless families can be linked.

Developing a comprehensive and coordinated system of homeless services is counterproductive if homeless families will be returning in a few months to underfunded, overwhelmed mainstream services. There is a need for continued linkages to services such as subsidized child care, Head Start, developmental services, prenatal care, and substance abuse treatment.

- Lack of attention to the special needs of families while they are homeless creates barriers to access to mainstream services.

  While homeless families resemble their tenuously-housed counterparts in most ways, homelessness presents practical problems such as transportation, child care, and lack of informal supports that must be addressed to deliver services effectively. Some adaptations to mainstream programs include the following:

  - Encourage flexibility in WIC programs through innovations that address the realities of shelter life for homeless mothers such as modified food packages and shelter-based certification and voucher distribution.

  - Allow for modifications in Head Start so programs can accommodate homeless children and families; modifications might include expanded hours of operation or waiving performance requirements regarding attendance and followup.

  - Allow for flexibility in use of funds and for modifications in the performance incentives for employment and training programs that will encourage them to serve homeless adults with lower skill levels and multiple problems.

  - Encourage States to provide transportation for educational access for homeless students.

- Lack of followup means no one knows if the service system is effective or not.

  Among its many advantages, followup can help determine the extent of recidivism among homeless families. Knowing the extent of recidivism is essential to defining the role of the service system for homeless families. Followup can also reduce the need for additional steps in the housing continuum; if families can be followed into permanent housing, support services can be tailored to their needs and gradually withdrawn as they become able to assume more independent lives.

  Some ways to enhance followup might include the following:

  - Incorporate followup as an appropriate use of funds as it already is for Health Care for the Homeless and Head Start.

  - If possible, vest a single entity with responsibility for followup. Ideally this entity should have access to an updated address database, such as the AFDC database, which is likely to include families after their period of homelessness has ended.

- Where a single entity cannot assume responsibility for followup, encourage programs to track participants at periodic intervals for at least a year using a variety of techniques such as mail-back cards, telephone inquiries, or designated followup staff.

- Develop incentives for families to stay in contact with the system after they leave services; one incentive might be continuation of services such as child care beyond the period of program participation.

- Services are fragmented and duplicative.

  Human services are organized categorically; unfortunately, the problems of homeless families cross traditional categories. Coordinated services planning, or case management, while not a panacea, is clearly an enhancement. Case management can minimize duplication of efforts and record keeping, vest responsibility in one place, and ease followup so that intensity and mix of services can be varied as the family's needs change.

  Some ways to enhance coordinated services planning might include the following:

  - Incorporate case management as an appropriate use of program funds.

  - If possible, centralize case management in one entity such as a multi-services center. This minimizes the number of case plans being developed for a single homeless family and ensures that families who do not participate in services such as shelter or health care, where case management is currently most likely to take place, have access to coordinated services planning.

  - Develop strong ties between the case management entity, the public housing system, and the entitlement system. Housing and entitlements are the cornerstones of short-term self-sufficiency for homeless families; case planning should be able to offer these resources.

  - Encourage maximum client participation in developing the case plan.

- Inadequate links between services and housing means support services end when they are needed most to sustain independent living.

  Permanent housing is often not under the control of the human service public and non-profit agencies that are such an integral part of the homeless services system. Efforts to carry social services forward once the family is permanently housed may meet with bureaucratic obstacles. One result is the creation of still more steps in the homeless housing continuum to prepare the family for permanent housing that they can maintain without support. A few modifications would make permanent housing more accessible even to homeless families with multiple problems:

- Encourage services-enriched housing models that house the family permanently and provide a mix of support services that are tailored to the needs of the family.

- For special needs such as substance abuse or mental illness, encourage residential programs that can accommodate children while the mother is in treatment or child care options that can provide long-term 24-hour child care.

IV. Summary

The programs and initiatives described in this report represent the best efforts of five diverse communities to address the problems of homeless families with children. There are advantages and disadvantages to the approach taken by each city. While five cities is far too few to draw sweeping generalizations for the rest of the Nation, the information presented in this report is useful in highlighting promising approaches to serving homeless families and in identifying program, policy, and research issues that may warrant further attention.

Chapter I

Introduction and Purpose

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In July 1990, Macro Systems, Inc., under contract to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (DHHS), was commissioned to undertake an exploratory study of the service system for homeless families with children.

It is widely believed that throughout the country a fairly large number of programs exist to respond to the needs of homeless families; one purpose of this project was to facilitate community-based efforts by identifying and describing particularly promising programs and practices and analyzing the roles of various levels of government and of the voluntary sector in providing services. The study objectives included the following:

- Describe the specialized needs of homeless families, and provide insights into the prevalence of this population and factors contributing to family homelessness.
- Identify five program configurations designed to meet the needs of this population that are widely regarded as model approaches.
- Examine these program configurations in-depth.
- Identify policy issues and barriers affecting programs for homeless families.

The study was intended as an exploratory study to examine the ways in which existing programs or service delivery systems have adapted to meet the needs of homeless families with children. Through a comprehensive literature review, telephone discussions with national experts who are familiar with issues and programs serving homeless families with children, and telephone discussions with providers, advocates, and agency officials in selected cities that are experiencing a significant problem with family homelessness, the study team identified the key issues, model and innovative approaches, and made preliminary selections of cities for in-depth site visits. The study team conducted case study site visits in five cities: Atlanta, Georgia; Baltimore, Maryland; Boston, Massachusetts; Minneapolis, Minnesota; and Oakland, California. In each city, the team identified for interviews those programs and agency contacts who could best provide a comprehensive picture of the service delivery system for homeless families with children. The findings of the site visits were used to identify policy and service delivery issues related to meeting the needs of homeless families.

The information in this report is presented in the following order:

- An overview of the problem of homeless families with children
- The methodology used in each component of the study
- A discussion of the context for homeless services
- Key cross-site findings from the case study site visits
- Key policy and program issues and barriers

This report will serve two primary purposes; one at the Federal level and one at the local level. At the Federal level, it will provide a mechanism for highlighting policy issues identified through the study process and will summarize suggested service delivery approaches. At the local level, the report will serve as an inventory of information for communities that currently face the problem of family homelessness.

Chapter II

Overview of the Problem

Chapter II. Overview of the Problem

This report is divided into two volumes. Volume I begins with an overview of the numbers, characteristics, and service needs of homeless families with children. Subsequent sections in this volume include a discussion of the study methodology and the study findings.

Volume II explores the experience of five cities in detail, outlining the characteristics of each city's homeless population, the response to the problem, and service delivery system comprehensiveness. Each city case study also includes descriptions of innovative service programs identified.

I. Introduction

Prior to the 1980s, the profile of a homeless person was a middle-aged, single man, with a chronic alcohol problem, frequently found sleeping on park benches or grates. In the past decade, the ranks of the homeless have swelled to include families, usually composed of young mothers with pre-school children and infants.[1] Compared with the homeless population of 30 years, homeless Americans in many cities now include more minorities, families, women, and younger people.[2] According to best estimates, between 25 percent and 41 percent of all homeless *individuals* are members of homeless families;[3] [4] between 10 percent and 15 percent of all homeless *households* are homeless families with children.[5] A 1989 report by the General Accounting Office (GAO) estimated that 68,000 children and youth age 16 and younger may be members of homeless families.[6] Data on unaccompanied youth are scarce; however, the GAO suggests there may be as many as 208,000 unaccompanied homeless youth each year.

The extent and rapid growth of the problem of homelessness among families with children has demanded a response beyond the local emergency shelter system. Recognizing that the causes and consequences of homelessness are complex, a variety of government programs, legislative initiatives, and private efforts have sought to prevent homelessness by bolstering the self-sufficiency of individuals and families at risk, in addition to ameliorating the immediate effects of homelessness by providing emergency food and shelter.

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[1] Institute of Medicine. *Homelessness, health and human needs*. Washington DC: National Academy Press, 1988.

[2] U.S. Department of Housing and Urban Development (HUD). *A report to the secretary on the homeless and emergency shelters*. Washington DC: HUD, Office of Policy Development and Research, 1984.

[3] U.S. Conference of Mayors. *A status report on hunger and homelessness in American cities in 1989--a 27-city survey.* Washington DC: US Conference of Mayors, 1989

[4] U.S. Department of Housing and Urban Development (HUD). *A report on the 1988 national survey of shelters for the homeless.* Washington DC: HUD, Office of Policy Development and Research, 1989.

[5] Burt M, Cohen B. *America's Homeless: Numbers, characteristics, and programs that serve them.* Urban Institute Reports;89-3. Washington DC: Urban Institute Press, 1989.

[6] U.S. General Accounting Office (GAO). *Children and youth: About 68,000 homeless and 186,000 in shared housing at any given time.* GAO/PEMD-89-14. June 1989.

Understanding the characteristics of homeless children, youth, and families and the factors that lead to homelessness is a prerequisite to identifying their service needs. This chapter explores the extent of homelessness among children and families, and discusses the interlocking causes of this growing national problem. The causes of homelessness--and the needs of the homeless--differ for families with children, homeless youth, and single people, and even from individual to individual. Exhibit 1 illustrates the causes and effects of family homelessness. Understanding the various factors that lead to homelessness among families is critical for designing programs that can prevent future episodes of homelessness and limit their negative effects on families and children.

II. Extent and Nature of Homelessness Among Families

A. Homelessness in General

Estimates of the size of the homeless population vary based on the source of the estimate and the methodology. A precise count of the number of homeless is and probably will remain elusive. At the lower end of the spectrum, a 1984 HUD study estimated the number of homeless to be between 250,000 and 500,000,[7] while a 1984 study by the National Coalition for the Homeless suggested that this number might have been as high as 2.5 million.[8] A more recent Urban Institute study estimated that the homeless population was between 500,000 and 600,000 during a seven-day period in 1988.[9]

Regardless of the uncertainties about the exact numbers, it is clear that homelessness did grow between 1984 and 1987 and may well be continuing to grow. Cities across the nation are finding that despite their increased numbers of shelter beds, they still cannot meet the demand. In its 1989 survey of 27 cities, the U.S. Conference of Mayors (USCM) found that in all but three cities, requests for emergency shelter increased an average of 25 percent; more than one-fifth of these requests could not be met.

The Stewart B. McKinney Homeless Assistance Act, passed in 1987, defines a homeless person as "...an individual who lacks a fixed, regular, and adequate nighttime residence; and an individual who has:

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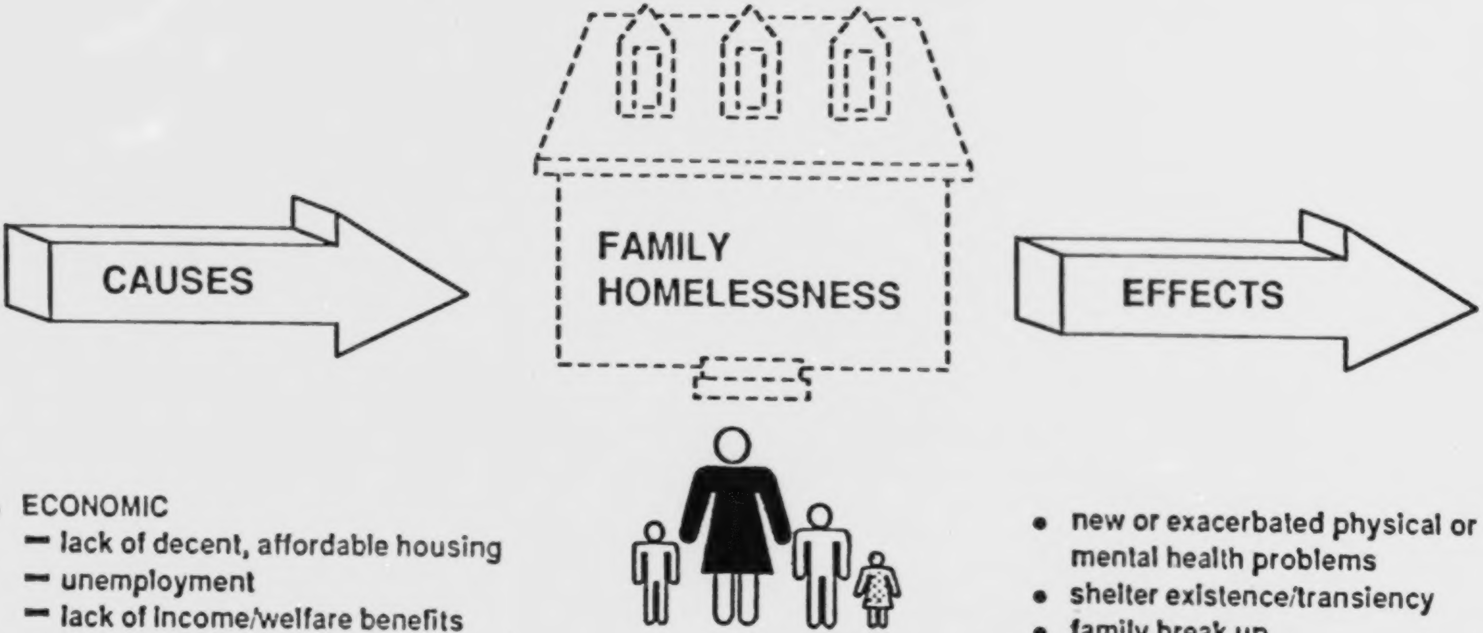
[7] HUD, 1984, op. cit.

[8] National Coalition for the Homeless. *American nightmare: A decade of homelessness in the United States*. National Coalition for the Homeless: Washington DC, 1989.

[9] Burt and Cohen, 1989, op.cit.

EXHIBIT 1

CAUSES AND EFFECTS OF FAMILY HOMELESSNESS



CAUSES

FAMILY HOMELESSNESS

EFFECTS

- ECONOMIC
  - lack of decent, affordable housing
  - unemployment
  - lack of income/welfare benefits
- INDIVIDUAL
  - lack of support networks
  - substance abuse
  - family violence
  - physical or mental health problems
  - single/early parenthood
  - lack of education and training for employment

- new or exacerbated physical or mental health problems
- shelter existence/transiency
- family break up
- substance abuse
- disruption of child's education
- child development/regression problems
- child abuse and neglect
- reduced access to needed services

- a primary nighttime residence that is a shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- an institution that provides a temporary residence for individuals intended to be institutionalized; or
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."[10]

In addition to those who are literally homeless, many individuals and families live in situations that leave them precariously close to homelessness. They may live with friends and relatives or, as in the case of the working poor, may be struggling to pay increasing percentages of their limited incomes for housing. Numbering in the millions instead of the thousands, these Americans are not yet among the homeless, but should be noted in any discussion of the problem's magnitude.

B. Homeless Families with Children

For the purposes of this study, homeless children and homeless families will be defined as follows:

- *Homeless children* are pre-school and school-age children who are homeless with one or both parents, or with a parent substitute (such as another adult relative).

- *Homeless families* consist of one or both parents who are homeless, accompanied by dependent children. In some cases, families may also be accompanied by other extended family members--grandparents, grandchildren, the parent's partner, and his or her children.

The most recent studies using national samples indicate that about 25 percent of the homeless are members of homeless families,[11] and that homeless families with young children are the fastest growing subgroup of the homeless population.[12] The proportion of homeless families varies widely from city to city. The U.S. Conference of Mayors' 1989 survey of its member cities found that family homelessness ranged from 14 to 78 percent. A Partnership for the Homeless study of 46 major cities found almost as wide a disparity--15 to 64 percent. Each survey identified several cities where homeless families had become the largest subgroup of the homeless.

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[10] Senate and House of Representatives of the U.S. *Public Law 100-77: general provisions of the Stewart B. Mckinney Homeless Assistance Act.* Washington DC: July 22, 1987.

[11] U.S. Conference of Mayors, 1989, op. cit.

[12] Bassuk EL, Rosenberg L. Why does family homelessness occur? A case control study. *American Journal of Public Health* 1988;783-788.

Estimates of the number of homeless children vary widely as well. Table 1 presents a range of estimates. From 61,500 to 100,000 children are homeless each night; from 310,000 to 500,000 are homeless each year.[13]

As with counts of the general homeless population, estimates cannot fully account for all the homeless or those near homelessness. Although homeless youth and adults can be found living on the streets, this is much more rare for homeless families.[14] Instead, an increasing number of families with children are in doubled-up living arrangements with friends or relatives. Between 1980 and 1988, the number of families in these situations increased 36 percent.[15] A 1989 General Accounting Office (GAO) report estimated that approximately 186,000 children and youth are living in doubled up situations.[16] Although not all of these families were potentially homeless, several studies have noted that homeless families tend to arrive at shelters from doubled-up living situations, rather than directly from their own homes and apartments.

In addition, several other factors make the true extent of family homelessness difficult to quantify. First, victims of domestic violence living in battered women's shelters are not always counted among the homeless, although in many cases they are indeed homeless.[17] Second, homeless parents may distribute their children to family or friends, rather than risk losing them to the foster care system because of alleged environmental neglect. A joint Child Welfare League and Travelers Aid study of homeless families in eight cities found that 20 percent of families had left minor children with relatives, foster parents, or other adults.[18] One State found that homelessness was the primary cause of placement in foster care in 19 percent of cases studied, and was a contributing factor in an additional 40 percent of cases.[19] Third, families may be dismantled in order to gain access to the shelter system itself; shelters may not take them either if the family is too large or includes an adult or adolescent male. The U.S. Conference of Mayors study found that in 19 of 27 cities in the study, families had to be separated in order to be sheltered, either because of

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[13] Children's Defense Fund. *Homeless families: Failed policies and young victims.* Washington, DC: CDF, 1991.

[14] Filer RK, Honig M. *Policy issues in homelessness: Current understanding and directions for research.* [Unpublished manuscript], New York: Hunter College and City University of New York, 1989.

[15] Children's Defense Fund. *S.O.S. America. A children's defense budget.* Washington, DC: CDF, 1990.

[16] GAO, 1989, op. cit.

[17] Mihaly L. *Beyond the numbers: Homeless families with children.* Paper presented at "Homeless Children and Youth: Coping with a National Tragedy" Conference sponsored by Johns Hopkins University and the Institute for Policy Studies, 1989.

[18] Hall JA, Maza PL. *No fixed address: The effects of homelessness on families and children.* In: Boxill NA (ed). Homeless children: The watchers and the waiters. Child and Youth Services, Vol 14. New York: The Haworth Press, 1990.

[19] Tomaszewicz M. *Children entering foster care: Factors leading to placement.* New Jersey Division of Youth and Family Services, 1985.

TABLE 1

SELECTED ESTIMATES OF THE NUMBER OF HOMELESS CHILDREN

Source	Number of Children
National Academy of Sciences (1988)	100,000 children nightly
U.S. Department of Education (1989)	273,000 school age children annually
General Accounting Office (1989)	68,000 children nightly and 310,000 annually
Urban Institute (1989)	61,500 nightly
National Coalition for the Homeless (1990)	500,000 children annually

Source: Children's Defense Fund. *Homeless families: Failed policies and young victims.* Washington DC: Children's Defense Fund. January 1991.

space restrictions or other rules.[20] These family members who are separated from the family and end up staying at other shelters, with relatives and friends, or on the streets are usually not included in counts of the family homeless.[21]

III. Characteristics of Homeless Families

Nationwide, over three-fourths of homeless families are headed by single or divorced mothers in their late twenties. Two-parent families are more typical in the West, comprising 60 percent of homeless families in some areas. The ethnic background of homeless families is disproportionately minority, particularly in the inner cities. While most homeless mothers have had some high school education,[22] few have the job skills or experience to compete in today's economy; it is not uncommon for mothers to have limited work histories, and to be long-term AFDC recipients. One study showed that only 15 percent of homeless women with children obtain some income from employment.

Homeless mothers suffer higher rates (and longer histories) of medical problems, depression, substance abuse, and domestic violence than their counterparts among the housed poor[23], and are less likely to have access to informal support networks.

Typically, homeless families have two to three children, most of whom are preschool-age.[24] Consequently, the majority of homeless family members are children, who may spend their formative years without the basic resources necessary for normal development. Homeless children share with their parents the adverse effects of poverty and homelessness: poor health, emotional difficulties, multiple and severe developmental delays, poor nutrition, lack of privacy, and general deprivation. Preschool-age homeless children tend to have eating or sleeping problems and a history of physical abuse. They also tend to exhibit behavioral extremes--shyness or aggressiveness, and neediness or taking on adult responsibilities. These problems are further detailed in section VI.

IV. Causes of Family Homelessness

Having described the size of the population and some of the characteristics of homeless families with children, the discussion can now turn to some of the factors that can lead to homelessness. Most observers agree that the causes of homelessness include a complex mixture of structural factors--the availability of housing, employment, and child care, for example--and individual factors such as exposure to domestic violence, substance abuse, and mental illness.

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[20] U.S. Conference of Mayors, 1989, op. cit.

[21] Mihaly 1988, op. cit.

[22] Institute of Medicine, 1988, op. cit.

[23] Institute of Medicine, 1988, op. cit.

[24] Bassuk EL, Rubin L, Lauriat A. Characteristics of sheltered homeless families. *American Journal of Public Health* 1986;76:1097-1101.

In some cases, the line between structural and individual factors is very blurred. Substance abuse, for example, is an individual behavior. However, lack of access to treatment may perpetuate the abuse, and the availability of treatment depends in large part on the health care system as a whole. Dividing factors that may lead to homelessness into structural and individual categories is only one way to classify the many inter-related causes and effects of homelessness. Doing so will clarify not only the roots of homelessness, but the programmatic implications as well.

A. Structural Factors

As an extreme form of poverty, homelessness reflects many of the same forces that drive people into poverty and keep them there. Structural factors leading to poverty and homelessness are generally functions of the economy. They include, among others, the declining value of public assistance payments, a growing chasm between income levels and average rents, and a decrease in the availability of low-income housing. The impact of these economic factors has been exacerbated by changes in family structure, especially a sharp increase in the number of families headed by single women. Each of these is addressed below.

1. Family Poverty

Between 1979 and 1987, the number of families living in poverty in this country increased 35 percent. In 1987, 5.5 million families--the families of 12.4 million children--were living in poverty. Within this group, families headed by single women are over-represented. Of all families headed by single women, *46.1 percent* live in poverty. (In comparison, 17.6 percent of single-father families and 7.8 percent of married couple families are poor.)[25] Families headed by black women make up 14 percent of families with children (under 18), 34 percent of single-mother families, and 44 percent of poor single-mother families.

If homelessness is regarded as an extension of poverty, it is not surprising, given these statistics, that women head 75 percent of homeless families, and that they and their children may still be the fastest growing group among the homeless.

During the 1980s, many families have depended on two incomes to keep pace with inflation and the rising cost of living. For single-parent families at the low end of the wage scale, this has been much more difficult. For example, even after scheduled increases in the minimum wage take effect this year, a worker who earns the minimum wage and works full-time would still earn only 90 percent of the poverty-level income for a family of three. In 1985, the average poor family's income was not only below the poverty line, but $3,999

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[25] McChesney, 1988, op. cit.

below it, most families that end up homeless have incomes well below the poverty line.[26]

2. Public Assistance Programs

Among both homeless and housed poor mothers, Aid to Families and Dependent Children (AFDC), General Assistance (GA), and food stamps are the key--often the only--sources of income. Although AFDC, GA, and food stamp benefits appear to be the main source of income for homeless families, several studies have suggested that many homeless adults do not receive public assistance to which they are entitled. Separate surveys of the homeless in 12 cities reported between 18 and 55 percent of the homeless receiving some form of public assistance.[27] A recent study of homeless mothers found that only 33 percent were receiving AFDC.[28] A study of homeless families in Chicago indicated that this was not because families were not eligible for AFDC.[29] Instead, the majority of families were not receiving benefits for *administrative* reasons such as bad addresses and failure to show up for appointments. These reasons are much less common among the housed poor and point to an area where shelter services can play an important role.

The poor families and homeless families that receive AFDC rely on income from public assistance to survive. However, increases in public assistance payments have not kept up with increases in the cost of living. Nationwide, the average monthly AFDC payment for a mother with two children is $400;[30] even the lowest priced rental units in most urban markets would quickly consume half or more of that amount. Families who are completely or partially dependent on public assistance are left with the options of obtaining scarce subsidized housing, spending half or more of their income on rent, or doubling up with other families. The increasing numbers of homeless families reflect the fact that for many, homelessness is another option.

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[26] Leonard PA, Dolbeare CN, Lazere EB. *A place to call home: The crisis in housing for the poor.* Washington DC: Center on Budget and Policy Priorities and Low Income Housing Information Service, 1989.

[27] Brown et. al. 1983; Morse et. al. 1985; Breakey et. al. 1988; Mulkern et. al. 1985; Schutt et. al., 1988; Rossi 1987; Mowbray et. al. 1986; Farr et. al. 1986; Rosnow et. al., 1985; Piliavin et. al. 1987; Burt and Cohen 1989; Crystal et al. 1986.

[28] Burt MR, Cohen BE. Differences among homeless single women, women with children, and single men. Social Problems. 1989. 36:508:24.

[29] Rossi P, Fisher GA, Willis G. *The condition of the homeless of Chicago*. Amherst, JA: Social and Demographic Research Institute, 1987.

[30] Weinreb and Rossi, op. cit.

3. The Interaction of Income and Rent

The U.S. Department of Housing and Urban Development defines affordable low-income housing as that which does not cost more than 30 percent of a family's income. But by this standard, four out of five poor households cannot afford housing. This situation is the result of persistently low incomes on the one hand, and increasingly high rents on the other.

The Center on Budget and Policy Priorities reports that in 1985, the last year for which data are available, 45 percent of renter households--3.1 million households--paid at least 70 percent of their incomes for rent and utilities.[31] The typical poor renter household paid 65 percent of its income, while nearly two-thirds of these households paid at least half of their incomes for rent and utilities. The problem is even more severe among single mothers with children: a 1988 study in Massachusetts found that one-third of single mothers with children below the age of six were spending more than 75 percent of their income for housing.[32]

4. Availability of Low-Income Housing

Although the number of poor households has increased, the number of affordable units has declined. In 1970, there were 2.4 million more low-income units than low-income renter households. But by 1985, there were 11.6 million low-income renter households vying for 7.9 million low-rent units. Exacerbating this situation is the fact that up to one-third of these units are inhabited by households with incomes *above* the poverty line; other units are unavailable due to disrepair or turnover. In 1985, only 4.8 million of the 7.1 million occupied low-rent units were actually occupied by families with annual incomes below $10,000. Even for families willing to pay huge proportions of their income for housing, units are not available.[33]

B. Individual Factors

Substance use, domestic violence, health problems, and mental illness are among the characteristics of and problems experienced by homeless families and children. These are areas that affect individuals and families, often for generations. They may lead to homelessness by making employment untenable, by depleting income, and by severing crucial support systems with relatives and friends.

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[31] Leonard PA, Dolbeare, CN, Lazere EB. *A place to call home: The crisis in housing for the poor.* Center on Budget and Policy Priorities: Washington, DC, 1989.

[32] Childrens Defense Fund, op. cit.

[33] Center for Budget and Policy Priorities, op. cit.

While advocates and providers feel it is important to focus attention on structural causes, most acknowledge that individual factors either interact with or exacerbate the structural causes of a family's homelessness. Although the proportion of urban homeless families for whom these individual factors play a role seems to be rising, it is generally acknowledged that the factors play less of a role in family homelessness than in homelessness among single individuals. Nevertheless, these factors present additional challenges in designing programs to address the problem. The most frequently cited individual factors include domestic violence, substance use, single parenthood, and evictions. Mental illness also plays a role. The impact of these factors on family homelessness is discussed in more detail later in this report.

C. Interrelationships Among Causes

Advocates note that society tends to regard the homeless as if they are a separate population. While the differences between homeless families and their low-income housed counterparts are discussed throughout the report, in fact, homeless and low-income housed families face many of the same problems. The homeless are more accurately viewed as being on a continuum that includes the poor. The difference is that they lacked the "cushion" provided by formal and informal support systems, and were pushed to the extreme end of the continuum.

It is important to remember that all segments of society experience the individual problems and even the structural forces that can generate family homelessness. For example, not all substance users are homeless. Not all domestic violence cases end up in the shelter system. Not everyone who gets evicted or loses a job ends up in the system. For homeless families, these problems are exacerbated by a lack of personal resources and formal and informal support systems. The marginal economic situation of many families leaves them no buffer to protect against individual problems.

Distinguishing between the structural and individual causes of a family's homelessness is difficult, if not impossible. Is drug use the cause or product of homelessness? The stress of homelessness may lead to child abuse even in families where abuse was not previously a problem. Depression may be a precipitating factor in a family's homelessness or a rational response to a difficult situation. The section on special problems of homeless families, later in this chapter, discusses distinguishing structural and individual factors in more depth.

V. The Shelter System

The emergency shelter system has formed the core of the response to homelessness. The increased number of family shelters signals that the system, originally geared to single men, is adapting to changes in the composition of the homeless population. The fact that very few, if any, studies have observed families living on the streets is a tribute to the effectiveness of shelters in meeting immediate needs. However, length of stay and duration of service provision in family shelters in many cities has been increasing.

Most families only turn to emergency shelters after exhausting their support networks. A key finding from several studies is that homeless mothers, unlike poor but housed mothers, are often severely or completely disconnected from informal support networks.[34] By the time they have turned to shelters many families lack hope and self-esteem.

The living conditions in most emergency shelters range from poor to adequate. Some are typical barracks-style shelters that crowd large numbers of beds and people into one communal room, others offer families some privacy and shared living space. Whether it is in barracks-style shelters or with some privacy, families in shelters live under varying degrees of scrutiny from shelter staff and other homeless people. In many cases, shelter routines may inadvertently usurp a parent's discretion about disciplining a child or choosing meal and bed times. In addition, parents who are already under stress because of their situation may be contending with their children's behavioral problems as well.

Family's lives continue to be in disarray even after their shelter stay. The amount of time a family can stay in a shelter varies from a few days to up to six months, and families who are ineligible for emergency shelter or who have exhausted their allowable stay may go from shelter to shelter of to welfare hotels or motels, where they may stay for months. In hotels, families may be even more isolated from services, contact with other families, transportation, and recreation facilities for children.[35] In addition, welfare hotels and motels can be extremely unsafe, exposing residents to pervasive drugs and violence.[36] When families finally leave the shelter system, many shelter providers believe that because of the general lack of low-income housing, many families end up in substandard housing where again families and young children may be exposed to drugs and violence as well as environmental hazards such as lead paint poisoning.

VI. Special Problems of Homeless Families

The complex mixture of structural and individual factors causing family homelessness along with the crisis and upheaval involved in shelter life combine to create special problems faced by homeless parents and children. As is discussed in this section, many of these are problems afflicting all poor families; homelessness merely adds to the burden. These problems are described below.

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[34] McChesney KY. *Absence of a family safety net for homeless families*. Submitted to Sociology of Family Session, American Sociological Association, 1988.

[35] Gallagher E. *No place like home. A report on the tragedy of homeless children and their families in Massachusetts*. Boston, MA: Committee for Children and Youth, Inc., 1986.

[36] Shedlin, 1989, op. cit.

A. Health and Developmental Problems

The fact that most of the poor and the homeless are among the 37 million Americans who have no health insurance impedes their access to routine health care.[37] One study of a family shelter found that 58 percent of shelter residents were "medically homeless," despite high rates of medical problems among both parents and children.[38] Limited transportation and knowledge of available public health services may further curtail access. While Medicaid is an important source of health care for poor women and their children, because the link to Medicaid is typically through AFDC eligibility, Medicaid is heir to the same problems as AFDC enrollment--that is, most homeless families are eligible and may be receiving benefits for a period of time, but are dropped from the program for administrative reasons.[39]

It is estimated that between 16 and 20 percent of homeless mothers are pregnant[40], but they are unlikely to receive adequate prenatal or other routine, preventive medical care. Among both poor and homeless women, poor prenatal care and nutrition places their infants at increased risk of premature birth, low birthweight, and infant mortality. One researcher in New York City found that over 39 percent of the homeless pregnant women studied had received no prenatal care at all.[41] The same study found that this rate was three times higher than that of pregnant women in low-income housing projects. Sixteen percent of the babies born to the homeless women in the study were low birthweight, compared to 11 percent of the babies born to the housed mothers; the infant mortality rate was 25 deaths per 1,000 live births for homeless women, compared to 17 for housed poor women and 12 for New York City women in general.[42]

This lack of access to health care contributes to the significantly higher rates of preventable health problems among homeless families. Compared to poor, housed mothers, homeless mothers (and the homeless in general) are more likely to suffer from upper respiratory disorders, nutritional deficiencies, gastrointestinal disorders, anemia, and neglect of dental conditions.[43] Forty-eight percent of people who had lived in one city's shelters were found to have positive skin tests for tuberculosis.[44] In many cases, these conditions are exacerbated by problems with substance abuse.[45]

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[37] Hilfiker D. Are we comfortable with homelessness? *Journal of the American Medical Association* 1989;262:1375-76.

[38] Bass JL, Brennan P, Mehta KA, Kodzis S. *Pediatric problems in a suburban shelter for homeless families*. Pediatrics 1990;85:33-38.

[39] Rossi P, Fisher GA, Willis G. *The condition of the homeless of Chicago.* Amherst, JA: Social and Demographic Research Institute, 1987.

[40] Wright JD, Weber E. *Homelessness and health*. New York: McGraw-Hill, 1987.

[41] Chavkin W, Kristal A, Seabron C, Guilgi P. The reproductive experience of women living in hotels for the homeless in New York City. *New York State Journal of Medicine* 1987;87:10-13.

[42] Ibid.

[43] Wright and Weber, 1987, op. cit.

Despite their greater need for care, the lack of stability in homeless children's lives and the lack of health services in shelters means that their access to routine pediatric health care may be curtailed or nonexistent.[46] One result of this is that homeless children may not have up-to-date immunizations, making them susceptible to preventable diseases such as measles, mumps, and whooping cough.[47] One study found that 15 percent of the children in a family shelter did not have current immunizations.[48]

Homeless children living in shelters are exposed to a variety of diseases and infections: more frequent colds, skin rashes, ear disorders, gastrointestinal problems,[49] and hepatitis.[50] A recent study of parents and children in one family shelter found that 65 percent of children and 44 percent of their parents had at least one acute or chronic health problem.[51]

Poor nutrition is another health consequence of homelessness. With their meager incomes, few families can afford nutritious meals; shelters rarely offer three meals a day to families, and meals that emergency shelters are able to offer may not be nutritious or well-balanced. For infants and children with special dietary needs, nutritional problems are more acute.[52]

Homeless children under age five demonstrate high rates of developmental and socio-emotional problems. As young children they are particularly susceptible to the uncertainty and chaos of homeless life and often lack the resources necessary for normal development. Infants and toddlers may spend most of their time in cribs; preschoolers may spend an inordinate amount of time in small rooms or hallways that offer little opportunity for explorative and interactive play. Studies indicate that homeless children are considerably more likely than housed, poor children to manifest a developmental lag in one of the following areas: language, social skills, gross motor skills, and fine motor coordination. One study found that nearly 50 percent of all homeless children in the study demonstrated one of these delays compared to 16 percent of the housed children.[53]

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[44] Hilfiker, 1989, op. cit.

[45] Weinreb LF, Bassuk EL. Substance abuse: a growing problem among homeless families. *Family and Community Health* 1990;13(1):55-64.

[46] Alperstein G, Rappaport C, Flanigan JM. Health problems of homeless children in New York City. *American Journal of Public Health* 1988;78:1232-33.

[47] Ibid.

[48] Bass et al., 1990, op. cit.

[49] Wright JD. *Homelessness is not healthy for children and other living things*. In: Boxill NA (Ed.). *Homeless children: The watchers and the waiters*. New York: The Haworth Press, 1990.

[50] Fox ER, Roth L. *Homeless children: Philadelphia as a case study*. Annals of Social Work 1987:131-147.

[51] Bass et al., 1990, op. cit.

[52] Children's Defense Fund, 1990, op. cit.

B. Mental Health Problems

In general, unlike many homeless adult individual women, homeless mothers typically are not suffering from severe psychological problems such as schizophrenia. Psychological problems are most likely to be a result of homelessness rather than the cause. The most common mental illness reported among homeless mothers is clinical depression.[54]

Not surprisingly, the combination of shelter life and family problems often leads to developmental and emotional problems among homeless children. Bassuk and Rubin reported that a majority of children studied in family shelters in Massachusetts showed signs of developmental delays, anxiety, depression, and learning difficulties. Bassuk and Gallagher reported that many homeless parents describe various regressive behaviors among their young children as a response to homelessness.[55] These problems continue into school age; like their younger counterparts, homeless school-age children have been found to be anxious and depressed, to have behavioral problems, and difficulty learning.

The parents' individual problems--such as mental illness or substance abuse--and the stress of homelessness are often extreme enough to result in child abuse and neglect. Medical researchers have noted that crack use is highly correlated with child abuse and neglect, to an extent not seen with other drugs. When parents are unable to care for their children due to substance use or stress or depression resulting from homelessness, older children may assume parenting roles not only for their younger siblings, but sometimes for their parent(s) as well.

C. School Attendance and Performance

For school-age homeless children, school attendance and performance may be compromised. Limitations on the number of months a family can remain at a shelter can lead to frequent moves, and frequent changes in schools. Delays in transferring records and residence requirements for enrollment can also impede attendance by homeless children. A study of homeless families seeking shelter in eight cities, found that 43 percent of school-age children were not attending school at the time of the study.[56] Education provisions in Federal McKinney legislation have ameliorated this situation in many cities. Homeless children are more likely to have difficulty in school. One study of school-age children in shelters found 53 percent failing or performing below average, 43 percent had repeated a grade in school, and 25 percent were in some sort of special class.[57]

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[53] Rafferty Y. Developmental and educational consequences of homelessness. Paper presented at the Conference on Homeless Children and Youth. Johns Hopkins University. April 1989.

[54] Wright JD. *The national health care for the homeless program*. In: Green and White (eds), *The homeless in contemporary society*. Newbury Park, CA: Sage Publications, 1987; Wright JD, Knight JW. *Alcohol abuse in the national health care for the homeless client population*. Washington DC: National Institute on Alcohol Abuse and Alcoholism, 1987.

[55] Bassuk and Gallagher, 1990, op. cit.

D. Substance Abuse

Substance abuse appears to be less frequent among homeless families than among the single, homeless population. For example, one study found substance abuse problems among 12 percent of adults in families, versus 35 percent of single homeless adults.[58] Other studies indicate even higher rates among the single homeless population. For example, one researcher found that 85 percent of homeless men and 67 percent of homeless women in their study of one city had a problem with substance abuse.[59] In some settings, such as welfare motels, substance abuse rates may approach 100 percent.[60]

Nevertheless, high alcohol and drug abuse rates among homeless women are particularly troubling considering the high number of pregnancies among this population. When inadequate prenatal care is combined with substance abuse during pregnancy, infants are at risk for immediate health problems, as well as long-term developmental problems.[61] Drug treatment options for women are limited, particularly residential treatment. Many researchers believe that there is a general lack of familiarity with women's addiction issues.[62] Many programs categorically exclude pregnant addicts because of lack of obstetrical expertise and fear of obstetrical lawsuits.[63] For women with children, residential treatment programs that can provide child care are almost nonexistent; to participate in most such programs, women must relinquish their children to friends, relatives, or the foster care system before seeking care. Consequently, many do not seek care.

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[56] Hall and Maza, 1988, op. cit.

[57] Bassuk and Rubin, 1987, op. cit.

[58] Burt and Cohen 1989, op. cit.

[59] Breakey W, Fisher P, Kramer M, et al. Health and mental health problems of homeless men and women in Baltimore. *Journal of the American Medical Association* 1989;262:1352-57.

[60] Shedlin MG. *The health care of homeless mothers and children: Impact of a welfare hotel.* New York: Medical and Health Research Association of New York City, Inc., 1989.

[61] Weinreb and Bassuk, 1990, op. cit.

[62] Beschner G, Reed B, Mondanaro J. *Treatment services for drug dependent women.* Rockville, MD: National Institute on Drug Abuse, 1981.

[63] Chavkin MD. *Testimony before the House Select Committee on Children, Youth and Families*, April 27, 1989.

E. Domestic Violence and Child Abuse

A significant percentage of homeless women report past histories of domestic violence and current battering. The link between substance abuse and domestic violence in the general population holds true among the homeless as well, and in many cases either or both of these issues have precipitated family homelessness. In a study of homeless mothers in Massachusetts, one-third reported that they had been abused as children.[64] Another found that 40 percent of homeless mothers studied reported battering by a spouse or boyfriend.[65] Another found 22.9 percent of homeless mothers reporting abuse as children, and 41.7 percent were children of alcoholics.

Homeless children are also at increased risk of physical and emotional abuse by their parents, who may be suffering from a combination of substance abuse and emotional problems, and of violence from other shelter residents. This is a particularly acute problem in welfare motels.[66]

VII. Implications for Service Delivery

As the discussion of structural and individual factors demonstrates, homelessness is a much more complex and long-term problem than the loss of shelter might initially suggest. While the shelter system has responded to an immediate and overwhelming need, the homeless clearly require a vast array of services that are typically unavailable through the shelter system as it now stands: drug treatment, family planning, job training, health care, counseling, child care, income assistance, and affordable housing. These service needs are discussed below.

A. Services Addressing the Structural Causes of Homelessness

Affordable housing is the key structural element affecting homelessness, but it is also the hardest to control because of the macroeconomic factors involved and because the supply of affordable housing is impacted by both public and private sector decisions. Clearly, expanding the number of affordable units would lead to a sizeable reduction in the number of homeless families. Just as clearly, a solution of that scope is beyond the capability of the homeless service system and service providers that are the focus of this study.

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[64] Bassuk and Rosenberg, 1988, op. cit.

[65] Bassuk, Rubin, and Lauriat, 1987, op. cit.

[66] Shedlin, 1989, op. cit.

Within the confines of the homeless service system, what can be done to help families gain access to and retain affordable housing? Although limited in scope, rental assistance programs such as financial help with security deposits, first month's rent, and basic furnishings can help address the initial obstacles faced by homeless families.

Altering the orientation of public housing is another approach to changing the structural causes of homelessness. Lack of available public housing units, especially for large families, in most cities means that there are long waiting lists for housing. In other cases, relations between homeless advocates and the public housing authority are strained because of prior bad experiences with some homeless people in public housing. Most cities have low vacancy rates in general for lower-income housing, including public housing. When landlords can choose tenants, the homeless are perceived as the least desirable.

Some promising measures to alleviate these types of problems include various means of educating homeless persons about their options and about ways to avoid conflicts that may have led to losing their housing previously. For example, "housing counseling," where families are offered information on eligibility for low-income and subsidized housing, can help families obtain information that would be difficult to obtain otherwise. Landlord/tenant mediation techniques are also effective because withholding of rent in response to substandard housing often leads to eviction. Eviction is expensive for both sides; assistance in landlord/tenant disputes may help prevent homeless situations before they deteriorate.

The lack of affordable child care is another structural obstacle that can be alleviated. Without affordable child care, parents find it hard to get a job and thus be able to afford housing. Child care is critical to allow mothers to attend job training, search for employment, and go to work. Barriers to securing child care include the long waiting lists for subsidized child care and the transiency of the homeless family. Also, State regulations for child care settings are exhaustive and financially prohibitive for shelters that attempt to meet this need by providing in-house child care.

Structural changes in the economy have made job training and counseling imperative if the homeless person is to be fully employed. Current training is not always geared to the needs of the economy and often holds little promise of jobs in sectors paying sufficient income to escape homelessness, and the best program can choose among their applicants and often exclude hard-to-serve populations such as homeless mothers.

B. Services Addressing the Individual Causes of Homelessness

As mentioned earlier, domestic violence and substance abuse can precipitate homelessness in a variety of ways. Shelters that are geared to the special needs of victims of domestic violence can provide not only shelter, but also counseling to keep women out of abusive relationships. In addition, counseling provided through shelters can address male partners, as well as the women seeking shelter. For individuals with substance abuse problems, the short-term nature of most shelter programs is unfortunately at cross-purposes with drug treatment programs, which require longer-term involvement and a stable environment.

Inexperienced young or teenage mothers are often over-represented in shelters. Training in basic parenting and household management skills can help this group of homeless families cope with their situation, and can build skills that may alleviate future adversities. For example, young parents can benefit from financial counseling, such as how to work with a budget. Respite care for parents to relieve the constant presence of children in strained situations can also be beneficial to both parents and children. Psychological counseling and stress management may also be needed. Apart from the individual psychological problems of some homeless people, the condition of homelessness itself creates stress.

C. Cross-Cutting Services

Health care and general support services can be organized according to several different models. These models differ from more traditional shelter housing in terms of the intensity of services provided, the length of stay in a particular setting, and their ability to customize services for particular groups such as substance-using families and teenage mothers.

One model that applies to both health care and other services is "one-stop shopping," where people do not have to negotiate various agencies to receive care or assistance. Even when mainstreaming the homeless is a programmatic goal, providing services in this way may be necessary.

In some cases, services can be linked with housing. For example, "second-stage" or transitional housing often offers an array of health care, counseling and other services on-site, to encourage participation. Transitional housing may consist of congregated or scattered sites, with services either on-site or provided at various central sites. Finally, "services-enriched" housing describes permanent housing with services provided according to a case management plan.

D. Education

Education is the key service need for children. School districts have begun to assume primary case management responsibility for homeless students. Service needs in education are aimed at overcoming barriers to enrollment, attendance, and student success.

Services to eliminate enrollment barriers include eliminating residency requirements for attendance. In addition, school systems can encourage enrollment by establishing presumptive eligibility policies--that is, the school assumes responsibility for acquiring records, and does not make enrollment contingent on clearing up old records or problems. A more proactive role is for school system staff to visit shelters to advertise school programs, and to bring enrollment materials with them to facilitate the enrollment process.

Services to eliminate attendance barriers include making transportation available for children, especially where shelters are in dangerous areas of the city, and counseling homeless children who are having trouble coping with their situation. Sensitivity training for teachers may also help them avoid inadvertently drawing attention to students' homelessness. Tutoring may be required for homeless students who, however smart they are, have experienced gaps in their education.

Schools can also provide or arrange for basic health services for homeless students who are unlikely to be receiving needed care, and/or referrals to other services. Finally, schools can coordinate the provision of clothes and school supplies in unobtrusive ways, to make children feel more comfortable about attendance.

Services to eliminate barriers to student success include flexibility in scheduling assessments and screening for special services such as gifted, special education, or english as a second language (ESL). Homeless students often miss out on services because they never get evaluated. Some districts provide expedited evaluations. Many homeless students are excluded from early childhood education because application and selection is done periodically, and transient families may not be in the right place at the right time. Finally, learning enrichment and recreation programs can be particularly important to homeless children as a respite from constant communal living.

E. Coordination of Services: The Case Management Model

In addition to the component services addressing any one family's situation, advocates and providers agree that there is an overriding need for coordination of services. Coordination among providers and within the service plans of individual clients are both necessary. The term "case management" is often used to refer to this latter type of coordination.

At the provider level, coordination of services includes coalition-building among service providers. Informally, coordination among providers can improve the flow of information about the rights of homeless families and the availability of local services. In addition, formal linkages among key service providers, including representatives of welfare, child welfare, education, and housing agencies, can lead to improved referrals and access to service for homeless families.

At the individual level, coordination of services requires that the case management function be the responsibility of a specific component of the service system. Through this agency, the individual case manager would help inform the homeless client about a wide range of services, and, if necessary, assist with negotiating access to various services.

Ideally, case management should be directed at the family unit, not just an individual mother and/or child. For example, addressing the child as an individual may lead to foster care, whereas approaching the child as a member of a family that needs help may lead to a more stable family situation.

Clearly, the case manager should be familiar with the array of available services. In addition to helping homeless persons access formal services, however, case managers should be able to link formal and informal support networks. Although this type of assistance is crucial, an important long-term benefit of effective case management is that the homeless family can build its own capacity to define needs and use existing resources.

In order to be effective, case management services should anticipate long-term relationships with homeless persons, and should allow for follow up. Although labor intensive, comprehensive case management may be able to limit recidivism in the long run.

F. Mainstreaming vs. Parallel Services

Most advocates and providers favor mainstreaming, although they understand the good intentions of those who have developed separate service systems for the homeless out of frustration in accessing mainstream services. The advantages of specialized services are ready access and certainty of capacity. Also, for services such as education, clients do not risk the stigma of being identified by others as homeless. The disadvantages of developing a parallel service system are that the homeless are segregated from society, reinforcing the idea that they are different. Parallel systems may be more likely than mainstreaming to foster dependency on "helpers", and may lead to a separate--and, in time, unequal--service system.

The debate between these positions is most noticeable in the area of housing and, to a lesser extent, education. In the housing area, it manifests itself as a debate over transitional housing. Some feel that transitional housing is creating another step in the parallel service system and that the longer that settings such as shelters and transitional housing are used to house homeless people, the more they will begin to be perceived as legitimate and "normal" housing. While they acknowledge the need of families for support services, these experts advocate concepts such as "services-enriched housing"--permanent housing scattered throughout the community and accompanied by a case plan for support services and long-term case management.

In education, the debate between shelter schools and mainstreaming has largely been resolved in favor of mainstreaming. Shelter schools provided needed education when homeless students were receiving no services, when school districts put up residency and other roadblocks, and when the risk of stigma caused many homeless students to shun the school system. Proponents of mainstreaming recognize these problems but maintain that segregating homeless students will be as counterproductive for these students as it was for handicapped students whose segregation was justified for many of the same reasons. The education provisions of the McKinney Act address many of the problems of school access for homeless students. While many of the problems remain even after passage of the McKinney Act, few advocates express interest in perpetuating shelter schools.

VIII. The Federal Response to Homelessness

Appearing before the House Appropriations Committee in March 1990, DHHS Secretary Sullivan estimated that funding for the homeless from public, private, and nonprofit sectors had reached approximately $1.5 billion as of FY 1988, up substantially from the $300 million level in 1984. In FY 1991, the Federal government has authorized nearly $1 billion specifically for the homeless, an amount that may be contrasted to the 1987 actual appropriation figure of $470,948,000.[67] Of the total $1 billion authorized, the FY 1991 budget anticipates appropriations of approximately $883 million.[68] It should be noted that this amount does not reflect expenditures on homeless persons from the various entitlement programs for low-income individuals and families.

A. McKinney Act Programs

Federal programs for the homeless derive from various legislative authorities, but the single largest enactment on behalf of the homeless is the Stewart B. McKinney Homeless Assistance Act of 1987. This landmark legislation authorized a wide range of programs and benefits for the homeless: health care, emergency food and shelter, mental health services, transitional housing, education, and job training. Reauthorized for FY 1989 and 1990, the Act added programs for homeless veterans and homeless families receiving AFDC benefits. Funding for these programs totaled nearly $600 million in FY 1990 and approximately $753 million has been appropriated for FY 1991.[69] Programs administered by seven different Federal agencies comprise the major McKinney service programs for the homeless. McKinney programs are a combination of formula grant/block grant programs to States and other "entitlement jurisdictions" and discretionary and demonstration grant programs. The information which follows presents the major programs and, in parentheses next to each program, the amounts appropriated for FY 1991 where reliable figures were available; formula grant programs are listed in italics.

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[67] Departments of Labor, Health and Human Services, Education, and Related Appropriations for 1991. *Hearings before a subcommittee of the Committee on Appropriations, House of Representatives, 101st Congress, 2nd Session. Parts 2 and 5.* Washington, DC: U.S. Government Printing Office, 1990.

[68] Targeted Homeless Assistance Programs, FY 1991. Included in Final 1992 Budget Estimates, February 1991.

[69] Ibid.

McKinney Act Programs for the Homeless

Federal Emergency Management Agency
- Emergency Food and Shelter ($134 million)[70]

Housing and Urban Development
- *Emergency Shelter Grants ($73.2 million)*
- Supportive (including Transitional) Housing ($150 million)
- Supplemental Assistance ($0.3 million)
- Shelter Plus Care ($11.3 million)
- Section 8 (Single Room Occupancy) ($105 million)

Health and Human Services
- Health Care for the Homeless ($50.9 million)
- *Emergency Community Services ($41.1 million)*
- Mental Health Demonstrations ($5.9 million)
- *Mental Health Services Block Grant/PATH ($33.1 million)*
- Alcohol/Drug Abuse Demonstrations ($16.4 million)
- Homeless AFDC Families Demonstration (authorized but unfunded)
- Family Support Center Demonstration (authorized but unfunded)

Agriculture
- Food and Nutrition (Food Stamps) ($70 million)

Education
- Adult Education for the Homeless ($9.8 million)
- *Education of Homeless Youth and Children ($7.3 million)*

Labor
- Job Training for the Homeless (including Veterans) ($12.7 million)
- Reintegration ($2.2 million)

Veterans Administration
- Mentally Ill Veterans ($5.8 million)
- Veterans' Domiciliary Care ($15.8 million)

B. HHS Programs for the Homeless

Altogether, HHS will spend about $232 million in FY 1991 on the homeless, in both McKinney-authorized and non-McKinney programs. The major HHS homeless programs are found in the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), the Health Resources and Services Administration (HRSA), and the new Administration for Children and Families, a recent consolidation of the Family Support Administration (FSA), and the Office of Human Development Services (OHDS):

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[70] Budget figures are from Wasem, RE. Homelessness: Issues and legislation in the 101st Congress. *CRS Issue Brief*. Washington, DC: Congressional Research Service, Library of Congress, 1990 and Final Budget Estimates for FY 1992, op. cit.

- **ADAMHA**--All three ADAMHA Institutes fund special programs for the homeless, with varying emphasis on mentally ill persons, alcohol abusers, and drug abusers. Demonstration programs attempt to deal with the mental illness and/or substance abuse while improving residential status by increasing access to emergency shelter and housing. Such programs increase formal linkages among mental health and substance abuse treatment programs and other human service agencies; they also try to improve the economic status of the homeless through vocational training, job finding, and other quality of life improvements. ADAMHA grants also fund research on causes, correlates, and epidemiology of homelessness in the alcohol, drug abuse, and mental health population, and provide training and technical assistance.

- **HRSA**--This agency administers the Health Care for the Homeless Program which makes service grants to community-based organizations and coalitions to provide primary health care, substance abuse and mental health treatment, and case management services to the homeless; there are currently 109 such projects.

- **Administration for Children and Families**--The former FSA included the McKinney-authorized Emergency Community Services Program that assists families and individuals who are actually homeless or at risk of homelessness. Funds can be used to expand followup and long-term services that enable the homeless to move out of poverty, provide assistance in meeting social and maintenance needs, promote private sector assistance, and provide assistance under some circumstances to those who have received notice of foreclosure or eviction. This program operates via a national network of local anti-poverty agencies; its flexible nature makes possible virtually any service needed by the target population (food, shelter, counseling, case management, referral, medical and child care). In addition to programs housed in the former FSA, OHDS included many programs serving runaway and homeless youth.

- **Social Security Administration**--Although SSA has no specific McKinney Act or other mandated programs for the homeless, the agency has many outreach activities and special procedures to meet the needs of the homeless in obtaining Social Security or Supplemental Security Income benefits. These include a number of outreach demonstrations targeting the homeless population, provision of publications (local directories, services, etc.) to shelters, outplacement of social security workers at shelters, assurance of representation during the claims process, provision of representative payees, and check delivery programs.[71]

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[71] Departments of Labor, Health and Human Services, Education, and Related Appropriations for FY 1991, op. cit.

Federal agencies are working toward a comprehensive and coordinated program of services for homeless people that relies ultimately on mainstream programs rather than on a separate set of programs for this population. Although the efforts are fragmented, increasingly, they attack not only the lack of physical shelter but also the underlying causes of homelessness, stressing prevention and early intervention.

To help achieve coordination, the Department of Housing and Urban Development, the lead agency in addressing homeless issues, has instigated data collection activities on the State level. The statewide Comprehensive Homeless Assistance Plan (CHAP), which was replaced only very recently by a broader Comprehensive Housing Affordability Strategy [CHAS] encompassing the needs of both the homeless and the low-income housed populations, requires State and local governments to provide in-depth data on number and characteristics of the homeless within their jurisdictions, a detailed inventory of facilities and services for this population, and an expanded needs/resources strategy.[72]

IX. Conclusion

Homeless families with children differ from homeless single adults in terms of their characteristics and service needs. While shelters have adapted to some of the special needs of homeless families, many service needs are still unmet. In particular, the comprehensive spectrum of services that homeless families require--ranging from emergency food and shelter to job training, child care, education, health care, and substance abuse treatment--is beyond the scope of many shelters' limited resources. Fostering connections between shelters and existing services, helping homeless families negotiate the social service system, and designing effective new programs are all challenges faced by agencies, providers, and advocates responding to the problem of family homelessness.

The number of Federal agencies responding to the problem of homelessness has increased since the McKinney Act was passed in 1987. The range of service needs has warranted the involvement of these various agencies. While meeting these needs is important, many programs are adopting a dual focus: meeting the immediate needs of the homeless, and simultaneously providing job training or other services that aim to prevent future episodes of homelessness. In combination with other Federal programs -- such as AFDC -- that seek to prevent homelessness before it occurs, services that address prevention as well as immediate assistance offer the best potential for substantially reducing future levels of homelessness in our society.

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[72] Department of Housing and Urban Development. Comprehensive homeless assistance plan: Proposed rule. *Federal Register* Washington, DC: 1990;55:49.

Chapter III

Study Methodology

Chapter III. Study Methodology

In order to meet the diverse study objectives of reviewing the size of the population, identifying factors associated with family homelessness, and identifying and describing promising approaches to service delivery, the study used a mixture of methods. Each method constituted a phase of the study. These three phases included the following:

- Literature Review
- Unstructured Telephone Discussions
- Site Visits

Each phase is described in more detail below.

I. Literature Review

The study team conducted a review of the major academic and professional literature on family homelessness. The starting point of this literature review was materials supplied by ASPE. These were supplemented by sources identified through several automated bibliographic searches. The literature review focused on the following topics:

- Prevalence of and trends in family homelessness
- Segments within the larger family homeless population
- Causes of and factors associated with family homelessness
- Specialized needs of homeless families with children
- Programmatic responses to the specialized needs

While prevalence was an area of investigation, it was not the intent of the project to derive an estimate of the size of the family homeless population, but rather to summarize the results of the major prevalence studies undertaken to date.

In examining factors and specialized needs, the review dealt with the full range of needs, but focused on the following:

- Health care
- Developmental services
- Child care
- Education of children
- Employment and training
- Life skills

While the housing continuum for homeless families was an area of investigation, the focus was on the link between housing and the various social services as a family moved through the housing continuum, the manner in which individual services were packaged to provide comprehensive services for a family, and the adaptations that needed to be made to mainstream social services in order to meet the needs of homeless families.

Besides providing general background for the project, the purpose of the literature review was to identify experts for the expert discussion phase and cities with innovative approaches to providing services for homeless families that might be included in the site visit phase. The information from the literature review was incorporated into the background paper which comprises the overview in Chapter II of this final report.

II. Unstructured Telephone Discussions

In this phase of the project, unstructured phone discussions were conducted by study team members with 46 discussants. The discussants were drawn from two groups: national level experts and contacts who were familiar with the homeless service system in each of selected cities with a large family homeless population.

A. Expert Discussants

In consultation with ASPE staff, the study team compiled a list of national-level experts. These consisted mainly of nationally-recognized academic researchers, and representatives of national homeless advocacy or service organizations, national foundations, and professional and advocacy organizations with a more general human services interest including homeless families. From this list we selected 21 experts to schedule for unstructured discussions. These were telephone discussions of approximately 45 minutes on the following topics:

- Trends and prevalence in family homelessness
- Causes of and factors related to family homelessness
- Specialized needs of homeless families
- Model programs or approaches
- Recommendations of cities with innovative or comprehensive service systems for homeless families

A copy of the expert discussion guide is included in Appendix A. Experts were selected who represented a broad array of topical expertise and philosophies. A list of the participating experts is included in Appendix B.

B. City Discussants

Several sources were used to select the cities for further investigation. Prevalence data were obtained from the U.S. Conference of Mayor's December 1989 survey of 27 cities and from the 1989 survey of 46 cities by the Partnership for the Homeless. Both of these surveys consisted of self-reported data on the size and composition of the homeless population, and neither purports to represent all U.S. cities.

The study team integrated data from the two surveys and selected as a starting point for identification of cities any city which reported in either survey that family members constituted 40% or more of the homeless population. This resulted in an initial list of 14 cities. To these were added six additional cities that, based on the literature review or the expert discussions, appeared to have innovative or comprehensive services for homeless people in at least one service area relevant to the study. The initial 20 cities included the following, in alphabetical order:

- Atlanta, GA
- Baltimore, MD
- Boston, MA
- Chicago, IL
- Detroit, MI
- El Paso, TX
- Kansas City, MO
- Louisville, KY
- Minneapolis, MN
- New York, NY
- Newark, NJ
- Oakland, CA
- Philadelphia, PA
- Portland, OR
- Providence, RI
- Seattle, WA
- St. Louis, MO
- Trenton, NJ
- Washington, DC
- Wilmington, DE

Discussants in each city were selected by contacting a representative at the local homeless advocacy coalition or task force if one existed, or a representative of one of the more prominent service providers in the city. The study team also identified relevant public agency contacts in each city using the listings in the directory of the American Public Welfare Association. In each city, the study team conducted phone discussions with from one to four individuals depending upon the complexity of the service system and the comprehensiveness and uniqueness of the service system. Telephone discussions of approximately 45 minutes were conducted with each city contact; the focus was the following topics:

- Trends and prevalence in family homelessness
- Causes of and factors related to family homelessness
- Specialized needs of homeless families
- Gaps in the service system
- Funding for services
- Particularly innovative programs or approaches in their city

A copy of the city informants' discussion guide is included in Appendix A. A list of the participating city informants is included in Appendix B.

The information from the expert and city contact discussions was integrated with the literature review and is the basis for the overview in Chapter II of this final report.

III. Site Visits

The core of the data collection for this study was the case study site visits of five cities. The purpose of these site visits was to identify five program configurations that offer unique and effective approaches to meeting the needs of homeless families with children. The site visits included interviews with experts who could provide an overview of the system and interviews with service providers concerning the following program dimensions:

- Programmatic Configurations
  - facilities and locations
  - costs
  - funding sources
  - intake
  - goal setting
  - service delivery
  - followup
  - formal and informal links to other services
- Services
  - child development
  - education
  - life skills and activities of daily living
  - child care
  - health services
  - resettlement services
- Evaluation
  - qualitative
  - quantitative

In accordance with the provisions of the Request for Support Services, the team concentrated in site selection on choosing cities that met the following key criteria:

- Geographic diversity
- Diversity of approach
- Comprehensive array of support services for homeless families

The pool of 20 cities that were used in the expert discussion phase was reviewed against an expanded list of criteria including the following:

- *Coordinating Bodies*: Is there an active task force, coalition, or government coordinating body?
- *Government Role*: Is the government involved as a funder and/or administratively (i.e. in case management or intake)? Is the government role enabling or obstructing in the opinion of key informants?
- *Demonstration Projects*: Has the city been selected as a demonstration site for major government or foundation grants or programs?

- *Housing Continuum*: Does a full continuum of housing options appear to exist for low-income people? A full continuum consists of shelters, transitional housing, and links to permanent housing.

- *Transitional Housing Approach*: Main approaches include congregate sites, scattered sites, or both. A diversity of approaches was sought because each type has distinctive challenges in terms of providing support services.

- *Housing-Services Linkage*: A diversity of approaches was sought. The main models are on-site services vs. off-site services.

- *Social Services Continuum*: In general, how extensive is the array and availability of social services for homeless families?

- *Social Services Approach*: A diversity of approaches was sought. Main approaches include dedicated social services just for homeless population, priority for homeless population in accessing mainstream services, and competitive access to mainstream services.

- *Comprehensiveness of Services*: Have services been identified in all or most of the service areas relevant to the study?

- *Case Management*: A diversity of approaches was sought in terms of the comprehensiveness of case management and the locus of responsibility for this function. Responsibility may rest with government, with a housing provider, or some other entity.

Based on the results of this review against the expanded criteria and on the need to choose a set of cities which were geographically diverse, reflected a diversity of approaches, and offered comprehensive services for homeless families, the team selected 12 finalists from the initial 20 cities and rank-ordered them. From this rank-ordered list, ASPE staff selected the five site visit cities.

A pilot site visit was conducted in late October in Baltimore by the entire study team. The site visit discussion guide was revised based on the results of the pilot visit. A copy of the revised discussion guide is included in Appendix A.

Site visits were conducted in Minneapolis (November), Boston (December), Oakland (December), and Atlanta (January). The duration of the site visits was three days except in Atlanta where the Atlanta-based members of the study team conducted the site visit over a period of 10 days.

In each city, interviews were scheduled with a balance of advocates, agency officials, and providers. With advocates and officials, the interviews concentrated on a general overview of the service system, the political and funding climate, coordination efforts, and general gaps and barriers. With providers, the interviews focused on a series of program investigation points such as client characteristics, referral sources, on-site services, referral links, staffing, and financing. In all, 38 programs were visited in the five cities; in addition, the team interviewed 25 representatives of advocacy groups and public agency officials.

Site visit information from each city was compiled into a site visit report; program information for each program visited was compiled into a program profile. The draft program profiles were submitted to the providers for review and comment prior to incorporation into the final report. The site visit reports for each city were reviewed by at least one informant with a broad familiarity with the context and service system in the city. These site visits and program profiles are the basis for the findings of this study; complete site visit reports and the accompanying program profiles are in Volume II of this final report.

Chapter IV

The Context of Homeless Services

Chapter IV. The Context of Homeless Services

While the focus of the study was the provision of direct services to homeless families, in each city the site visit team found a variety of larger factors that influence the delivery of services and the effectiveness of the service system. This chapter discusses this "context" for homeless services; the following chapters discuss findings related more specifically to service delivery.

The system of services for homeless families is rarely a system, but rather a patchwork of unconnected or loosely connected services. In none of the cities visited does an organized system of homeless services exist. As with most social problems, the initial response has been undertaken by nonprofit and voluntary sector organizations. Most of those began responding over a decade ago to what they perceived would be a short term need. As the problem persisted and grew, these individual components have tended to establish links to other programs and to the mainstream system. Exhibit 2 illustrates some of the immediate needs of homeless families for which links must typically be made.

Coordination among organizations tends to be informal. Referral arrangements are usually "understandings" rather than contractual agreements. Governments have typically become involved as the problem grew too large or too persistent for voluntary organizations to manage alone. Each level of government has become involved, usually as a funding source for services and usually employing existing agency structures. Consequently, funding of services is not integrated; it is a mixture of government funds from diverse sources supplemented by grants, corporate and foundation philanthropy, and individual donations.

Although services are rarely arranged in an organized system, clearly the environment in which services are embedded greatly influences the direction and "flavor" of service delivery in each city visited. The elements of this environment include the nature and comprehensiveness of the mainstream human services infrastructure, the size and composition of the overall homeless population, local economic and structural conditions, the pervasiveness of individual problems among homeless families, the local political and funding structure, and corporate and public attitudes towards homelessness.

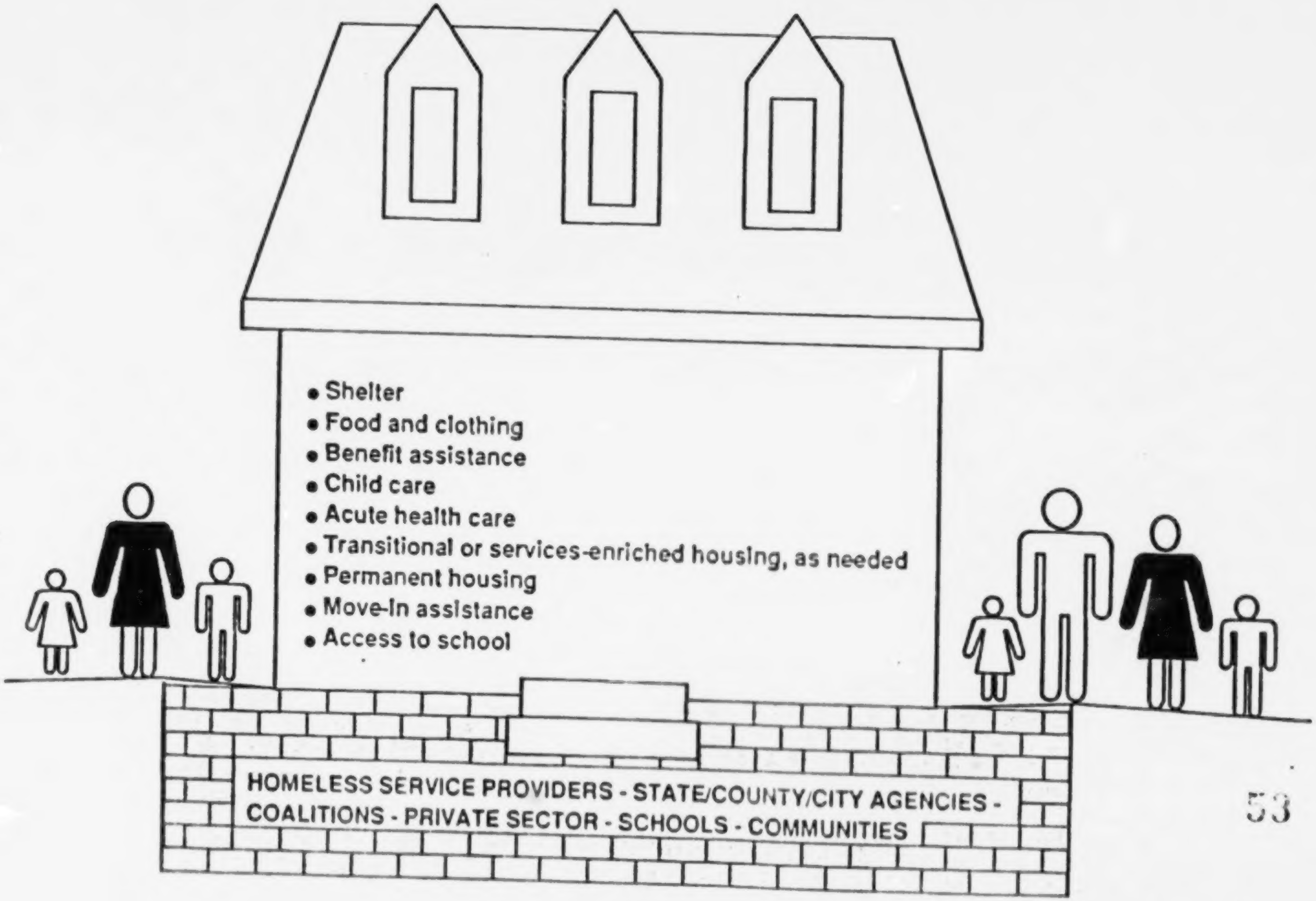
This chapter discusses patterns and themes related to the context of service delivery for homeless families that were detectable in the five cities visited.

I. Relationship to the Human Services Infrastructure

Virtually no informants--whether government, advocates, and providers--expressed a preference for creating a duplicate system of services for homeless families; instead, they said, create opportunities to link homeless families to the mainstream service system. Nevertheless, all cities have resorted to targeting at least some services to homeless families. The reasons are three:

EXHIBIT 2

IMMEDIATE SERVICE NEEDS OF HOMELESS FAMILIES



- Shelter
- Food and clothing
- Benefit assistance
- Child care
- Acute health care
- Transitional or services-enriched housing, as needed
- Permanent housing
- Move-in assistance
- Access to school

HOMELESS SERVICE PROVIDERS - STATE/COUNTY/CITY AGENCIES - COALITIONS - PRIVATE SECTOR - SCHOOLS - COMMUNITIES

- Mainstream services are often inadequate. Mainstream services such as health care are overwhelmed. Linking the family to mainstream services that are unavailable is no better than not linking them at all. Consequently, in some cities, the homeless services system provides dedicated services to ensure that the family gets any service.

- Homelessness is characterized by logistical obstacles which make mainstream services hard to access. Mothers need to bring their children with them unless there is child care; shelters may be at a distance from benefits offices; shelter intake schedules may interfere with job search or health care. These logistical obstacles mean that families must often choose among job, food, shelter, and services. To ensure that families receive the needed services, providers have sometimes opted for arrangements that make the service as convenient as possible. This includes providing services at the shelter, special clinics or locations just for homeless families, extended hours, or mobile services.

- Homelessness creates or exacerbates personal problems such as substance use and mental illness. Yet, the stress of homelessness makes families less likely to seek services other than those directed to the immediate housing problem. Again, dedicated services are a way to ensure that homeless families receive needed services which they are not inclined to seek on their own during a stressful time.

II. Size and Composition of Homeless Families

The five cities visited mirrored the national picture--homeless families are the fastest growing segment of the population; indeed, in Boston, some informants indicated that families were the largest component of the population (see Table 2).

The size of the family homeless population is hard to define accurately. Cities have varied capabilities for tracking the size of the homeless population, especially the single population. Some track nightly data and are not always able to avoid double-counting in calculating annual numbers. Most cities are able to count only those receiving services from homeless housing providers; yet many of the single homeless population are on the streets or in abandoned buildings. Nevertheless, most informants in the five cities could estimate the size of the family homeless population and agreed that the population is growing. Two additional factors confound developing an accurate estimate of the size of the population of homeless families in particular. First, most informants believe there are an enormous number of families at-risk of homelessness in each of the five cities. For every homeless family living in a shelter, advocates estimate that there are two to three families who are on the verge of homelessness because of unstable living conditions and who need the same support services as homeless families in order to sustain permanent housing. On the other hand, although there were no firm estimates for the cities visited, some research indicates that local policies that place homeless families at the top of lengthy waiting lists for subsidized housing or give other priorities for support services may attract some doubled-up families to the shelter system who might otherwise remain housed.

TABLE 2

FAMILY MEMBERS AS A PERCENTAGE OF HOMELESS POPULATION

City	Total Homeless	Percent Family Members
Atlanta(a)	35,000-47,000	30%
Baltimore(b)	22,250	20%
Boston(c)	3,613	19%-75%
Minneapolis(d)	10,720	50%
Oakland(e)	14,560	48%

(a) 1989 estimates from Atlanta Task Force for the Homeless of number of people experiencing homelessness in a year. Cited in: Atlanta Task Force for the Homeless. *Homelessness in Metro Atlanta II: An update of the 1987 working paper.*

(b) Total homeless is number of unduplicated individuals served by homeless housing providers in Baltimore City. Percent homeless family members is for Baltimore City. Source: Homeless Services Program. *1989 data collection analysis*. Baltimore MD: Maryland Department of Human Resources. 1989.

(c) Total homeless is one-night census for December 1988 as cited in Emergency Shelter Commission. *State of homelessness in the City of Boston: Winter 1990-91*. Boston MA: Emergency Shelter Commission. 1991. Percent family members sources include: 19%: Family members as a percent of all sheltered individuals as reported in Emergency Shelter Commission, *op cit.*; 75%: unofficial estimates from State Executive Office of Human Services as reported in the Comprehensive Homeless Assistance Plan.

(d) Total homeless persons calculated as follows: 3,720 members of homeless families based on county data indicating 1,200 unduplicated homeless families in 1989 who received Hennepin County shelter vouchers and average family size of 3.1. Single adult shelter users in 1989 totaled 7,000 based on estimates in Joint Task Force on Homeless Single Adults and Families. *Housing, shelter, and support services for homeless single adults: A partnership proposal*. Minneapolis MN. October 1990.

Percent family members is Statewide estimate from: Senate Counsel and Research. *Housing the homeless*. St. Paul MN: Minnesota Senate. February 1990.

(e) Estimates from annual survey of Emergency Services Network of Alameda County.

Second, as with the general homeless population, the size of the homeless population is determined by counting the number of families receiving services--especially shelter. Yet, many informants indicated that because the general public tends to be more sympathetic to homeless families than homeless individuals, it is often easier to open more family shelters than individual shelters. Therefore, "growth" in the number of homeless families in a particular city may not reflect a change in underlying conditions causing homelessness, but an expansion in the shelter system. The expanded system then accommodates more of the tenuously housed families who were always on the periphery of the system.

The composition of the family homeless population tends to be the same in most cities. Although geographic diversity was one criterion in site selection; in the end, homeless families in all five cities looked basically the same. They are disproportionately minority (usually African-American), and headed by young, single, females. The typical homeless family in all five cities has two to three young children.

While some informants reported that the number of intact families was growing, they were not a major component of the family homeless population in any of the cities visited. While some would assert that this is because of the lack of sheltered services for these families--i.e. there are intact families but they must be dismantled to gain access to shelters--the site visit team did not find large numbers of them even in the shelters that were able to accommodate these families.

That the majority of homeless families are headed by young, single, minority females should come as no surprise. These are the families least able to compete in the economy by virtue of poor education, few job skills, and little practical life skills experience. Yet they are expected to compete for a decreasing supply of affordable housing supported by entitlement benefits with declining real value.

Most families in the service system are from the local area. In only one city--Minneapolis--were large numbers of the homeless families in-migrants. As will be seen, the large number of in-migrants influences the nature of services in Minneapolis and the ability to link homeless families rapidly to mainstream services.

In all five cities, little is known about the fate of homeless families once they leave the shelter system. While some informants indicated that there are chronically homeless families, there is little data available to determine if this is true and evidence of chronic recidivists is hard to find. Where the data are collected, they appear to indicate that homelessness is an acute rather than chronic problem for individual families. For example, in Minneapolis, 1,200 different families received shelter vouchers during 1989, but only 10 percent were served more than once in the same 12 months.

In general, shelter stays are not very long in any of the cities visited. Boston, at 90 days, had the longest stays. Even in shelters that permitted long stays, the average stays of homeless families were considerably shorter. While some informants reported that families move from shelter to shelter, in general, informants believed that families left shelter for permanent housing. Advocates stressed, however, that the situation is less favorable than it seems. In many cities, anecdotal evidence suggests that some families are moving to permanent housing only because AFDC-Emergency Assistance (AFDC-EA) or a comparable source supplies security deposits and a few months' rent. The ability of these families to maintain housing is no more established than when they entered the shelter and they can be expected to return to the shelter system or a tenuously housed situation again in a few months. However, because some cities or providers limit the number of times you can access shelter and because AFDC-EA rules prohibit receiving benefits more than once in a 12-month period, when these families lose their housing, they are unlikely to return to the system and be counted among the recidivists. Still other families never attempt permanent housing; they tire of the shelter system or exhaust their shelter options and return to the unstable situations from which they came.

The duration of shelter stay is important because it influences what role emergency shelters can and should play in service delivery. If families are staying in the emergency shelter system for as little as 30 days, then putting resources into support services and dedicated services on-site at emergency shelters seems inappropriate. Families are in crisis, not receptive to intensive services, and view their situation as temporary. Furthermore, it is unlikely that major changes in a family's dynamics or problems can be accomplished in such a brief time. Even links to mainstream services are hard to establish since families may often leave the shelter before an intake appointment can be scheduled.

It would be more productive to use the time in emergency shelter as a respite or to link families to housing and entitlements that they will need as housed low-income families--which they will probably become again in a few weeks. Many shelters are already playing this role; however, others place their emphasis on a broad array of support services.

III. Structural Factors Related to Family Homelessness

In all the cities visited, affordability of housing was cited as the key factor in family homelessness. Even informants who acknowledged that personal issues contribute to family homelessness largely blame structural factors. Rents escalated throughout the 1980s, the urban economy is shifting to low-paying service jobs for those without education or skills, and the constant dollar value of entitlement benefits is falling. Add to this the deterioration of the housing stock and the loss of large numbers of affordable housing units to gentrification and downtown development, and maintaining independent housing becomes an impossible dream for many low-income families.

In all the cities visited, the gap between monthly Fair Market Rents (FMR) and monthly AFDC benefits is enormous. While HUD affordability criteria indicate that housing should consume approximately 30 percent of income after deductions, housing costs in all five cities made this infeasible unless the family secured public housing or subsidy. In Minneapolis, monthly FMR would consume 70 percent to 80 percent of monthly AFDC benefits excluding food stamps; in the other four cities, monthly FMR *exceeds* AFDC benefits excluding food stamps (see Table 3).

Because little private affordable housing is available in the five cities, the public sector plays a crucial role. Unfortunately, subsidized and public housing are in short supply in all five cities although those are the only housing options for women earning minimum wage or on AFDC that have potential to fall within HUD affordability guidelines.

TABLE 3

FAIR MARKET RENT (FMR) AS A PERCENTAGE OF MONTHLY AFDC BENEFITS

City	Monthly FMR[1]	Monthly AFDC[2]	FMR as Percent of AFDC
Atlanta(a)	$584	$272	215%
Baltimore(b)	506	377	134%
Boston(c)	803	539	149%
Minneapolis(d)	445	532	84%
Oakland(e)	763	694	110%

[1] For 2-bedroom apartment.
[2] For family of three; food stamps not included

(a) Atlanta Task Force for the Homeless, 1989. Figures for FMR and AFDC cited in: Atlanta Task Force for the Homeless. *Homelessness in Metro Atlanta II: An update of the 1987 working paper.*

(b) 1989 FMR and AFDC figures from Dolbeare, CN. *Out of reach: Why everyday people can't find affordable housing.* Washington DC: Low Income Housing Information Service. July 1990.

(c) 1989 FMR and AFDC figures from Dolbeare, CN. op cit.

(d) 1989 FMR figure from Dolbeare, CN. op cit. 1990 AFDC figures from Hennepin County staff.

(e) 1990 data from Alameda County staff.

AFDC benefits provide a stable, although inadequate, source of income for eligible homeless families. In all of the cities visited, the site visit team found that the vast majority of homeless families were screened for, eligible for, and would likely be linked to AFDC benefits by the time they left the shelter system. However, there is a significant disparity in monthly benefits from State to State even after accounting for differences in the cost of living--for example, Georgia's monthly benefit is only about half the size of Minnesota's. Also, most States have not raised benefits significantly since about 1983, so real purchasing power has fallen dramatically, especially as a proportion of poverty line income.

Though benefits are inadequate, AFDC can be a stable income source for homeless families who find public or subsidized housing. Dual receipt of housing assistance and AFDC gives them the leeway to enroll in schooling or training that can qualify them for better paying jobs as opposed to jobs that provide wages only marginally more than welfare, less if child care costs are factored in.

The factors at the root of family homelessness also create a large pool of families at-risk of homelessness. Yet in the five cities visited, prevention of homelessness is not yet an emphasis despite the interest of advocates, providers, and officials in addressing prevention. Services are focused on the acute phase of the problem, although informants acknowledge that there may be two to three at-risk families for each one in shelter. The key reason is the lack of resources to meet even the acute need. To meet the needs of the far larger group of at-risk families would require much more.

Nevertheless, the project team found some innovative efforts underway. The most ambitious effort never really got underway. Massachusetts attempted to expand the eligibility criteria for the State's Chapter 707 rental subsidy set-aside program to include families who were at-risk because of high housing costs or unstable family situations. A formal assessment process would allow families to access subsidy money that had previously been restricted to those who were in the homeless system. Unfortunately, the economic downturn derailed the program before it got started. The assessment process does survive, but as a means of screening families for shelter services.

The team also found some efforts in public housing that attempt to address prevention by delivering services to residents to build their capacity to sustain permanent housing. The best examples were the Family Development Centers and Family Support Centers in selected Baltimore public housing projects and low-income neighborhoods. These offer an assortment of formal programs and drop-in services such as literacy education, employment training, child care, and personal counseling and support. While these programs do not target homeless families, they aim to intercept marginal families who might otherwise fall into the homeless system. The recently authorized (but not yet funded) Family Support Center provisions of the McKinney Act are based on programs such as these. Using existing funds, HHS and HUD plan during FY 1991 to jointly fund between 10 and 20 such programs in communities across the country.

Elim Transitional Housing, Inc. in Minneapolis combines rental subsidy and services-enriched housing. Elim provides a rental subsidy to keep families in their current or comparable housing and uses coordinated services planning to link them to services in the community that will sustain them once they leave the program.

IV. Individual Factors

Advocates are often reluctant to discuss the role that individual dysfunction plays in family homelessness. Advocates fear that the dysfunction will be blamed for the homelessness. As one informant noted, "Homeless families are under a microscope. If you put anyone under a microscope, you will find flaws." The fact is that many families have dysfunctions, yet most families are not homeless.

As the national research in Chapter II indicated, substance use and mental health are less important as contributing factors to family homelessness than they are to single adult homelessness. However, reliable city data are hard to find. Often they are based on limited samples or one-night counts. The anecdotal experience of the five cities is consistent with the results of the national research; most informants indicated that fewer families than single homeless individuals were afflicted with personal problems that played a major role in their homelessness. Nevertheless, there was a pervasive sense in all five cities that the family homeless population, especially the shelter population, is becoming more dysfunctional. Drug use is of particular concern; crack cocaine use seems to have increased recently in most of the cities visited and has adversely affected the ability to stabilize homeless families.

In addition to drug use, domestic violence is recognized as a significant and increasingly important factor in family homelessness. All informants reported that for a significant percentage of families, domestic violence was the precipitating cause of the homelessness. Research in Minneapolis indicated that domestic violence was the main cause of homelessness for about one-quarter of homeless families and a contributing factor for an additional 50 percent.

While all cities visited had a network of domestic violence services including outreach, shelters, and crisis services, in none of the cities was this network connected to the homeless services system, even though the incidence of domestic violence clearly has an impact on utilization of homeless services. Typically, the two systems are funded separately, report to different agency offices, and perform outreach through autonomous networks. Yet the factors that influence homelessness are also likely to influence domestic violence; in the opinion of some informants, the homeless shelter system is increasingly experiencing the overflow from an overburdened domestic violence system.

As many informants noted, determining the relationship between homelessness and personal problems is difficult because the two interact. Some may be homeless because of personal problems. Others will experience personal problems because of their homelessness; these will make it that much harder to obtain permanent housing.

V. Political and Funding Climate

Services for homeless families are still provided predominantly by nonprofit and voluntary-sector agencies. The role of government and the prominence of its role differs in all five cities, but in none of the cities is government the major service provider.

Funding for homeless services is a mixture of public, corporate, foundation, and individual contributions. Government funding may come from local, State, or Federal governments or a combination of these, and may mix entitlement programs, block grants, and competitive grant programs. Programs encompassed under the McKinney Act include some, such as the Emergency Shelter Grant (ESG) program, that direct money to States and cities for allocation to service providers as well as many competitive grant programs for which service providers can apply directly.

The various levels of government play a crucial *funding* role in all the cities visited. Local and State governments are providing considerable amounts of their own resources as well as allocating funds from assorted McKinney programs such as Emergency Shelter Grants (ESG) and the other general block grants (Community Development Block Grants and Community Services Block Grants). Whether any level of government takes a more prominent *administrative* role is related to the manner in which shelters are funded. For example, in both Minneapolis and Boston, the AFDC-EA program is the main funding source for emergency shelters. In both these cities, documenting shelter utilization in order to file for AFDC-EA reimbursement from the Federal government has necessitated a centralized voucher and assessment system. Government (the State Department of Public Welfare in Boston, Hennepin County in Minneapolis) has assumed a prominent role in controlling access to shelters.

The assignment of responsibilities for homeless services among the various levels of government, and between government and nonprofit sectors varies in all the cities visited. In general, the leading actor in addressing service issues is either a nonprofit task force or coalition or a key provider. In both cities where shelters are funded through AFDC-EA, government also played a leading role, although both Boston and Minneapolis have visible homeless coalitions that also play a coordinating role.

The roles assigned to State, county, and city governments are even more varied; the variety arises out of differences in the way social services are provided. Massachusetts and Maryland have State-administered social service systems, Minnesota and California are locally administered, and Georgia is a hybrid--State-administered but with service delivery through county offices. Because entitlements are the key mainstream service for homeless families, the level of government providing social services is the one which is most prominently involved in family homeless issues. In Massachusetts, the State Department of Public Welfare was most prominent; in Minneapolis and Oakland, the counties were key; in Baltimore, where the City of Baltimore is legally equivalent to a county, the city played the most visible role.

With the exception of Baltimore, cities are not as involved as other levels of government, although they usually play a very active role in service provision for single homeless individuals. There is virtually no city involvement in Oakland, some channeling of grant funds in Atlanta, and mainly a capital development role in Boston and Minneapolis.

Multiple political jurisdictions complicate service delivery for families because a patchwork of political divisions is overlaid on an already fragmented service system. Coordinating services among agencies at the same level of government is difficult; among agencies in different levels of government is harder still. In addition, where there is a major county role in social services, delivery can get complicated because families are transient. As they cross city, county, and school district lines or where cities encompass more than one county or school district, continuity of service is difficult. In Atlanta, for example, families must reaffiliate with a new social services office if they cross county lines. Yet, one of the largest family shelters is in a different county than the one in which most homeless families originate.

Funding for homeless services is varied and idiosyncratic from city to city. Since the study was to focus on cities with comprehensive or exemplary service systems, it is not surprising that all five cities have been successfully attracting Federal funds. All are using McKinney money extensively, and, besides FEMA and the formula grants, have won many McKinney demonstration grants. State funding differs in each of the five States in both level and type. Some States focus their funding on a specific portion of the service system; for example, Minnesota devotes much of its State funding to transitional housing. Other States emphasize specific activities that may permeate the service system. For example, Georgia's State funds finance case management for mentally ill and substance using homeless persons and resettlement services for homeless families.

In all five cities visited, informants agreed that the Federal funding response has been too focused on demonstration grants programs, requires too great a proportion of local matching funds, is not prevention-oriented, is not well coordinated, and does not provide sufficient resources to attack the root of the problem which is affordable housing. Some of these concerns are addressed by newly authorized provisions of the McKinney Act. For example, the scope of activities that can be funded under ESG and FEMA has been expanded to include more prevention. A similar expansion was made in the Emergency Community Services Grant program in the 1988 McKinney Act amendments.

VI. Social Climate

Corporate and business relations with the advocate and provider community are generally good. Although there have been some rocky periods--for example, a perennial proposal for a vagrant-free zone in downtown Atlanta--the relations are basically good. Most cities could point to fund-raising efforts by the business community and informants in all five cities indicated that corporate philanthropy was a significant factor in donations.

While there has been extensive media speculation about an anticipated backlash by the public against homeless people, that has not yet been the case in any of the cities visited. No one reported a decrease in public interest or volunteerism. Indeed, where survey data were available, as in Boston, the public seems very sympathetic to the plight of homeless people and generally ascribes the problem to housing costs; many see themselves as only a few paychecks away from homelessness.

Chapter V

Cross-Site Findings: Coordination of Services

The case study site visits to five geographically diverse cities allowed the study team to hold discussions with staff of nearly 40 programs providing services to homeless families with children and with 25 officials and other experts familiar with issues concerning homeless families in each city. The observations of the site visit team and the comments of the staff and system experts form the basis of the cross-site findings. These findings fall into two overarching categories: coordination of services and comprehensiveness of services. This chapter presents a detailed discussion of the six findings related to coordination of services; Chapter VI discusses 13 findings related to comprehensiveness of services.

As the problem of homelessness among families with children grew in the 1980s, so did the response. In each of the five cities visited, the site visit team discovered a wide array of efforts to provide planning and coordination to meet the needs of homeless individuals and families. There were efforts at the agency level, provider level, and individual family level. Some were government run; many, if not most, however, were nonprofit led, with government participation. Without a doubt, coordination and planning vehicles, such as task forces and coalitions, served as the impetus for a larger community response to the problem of homelessness.

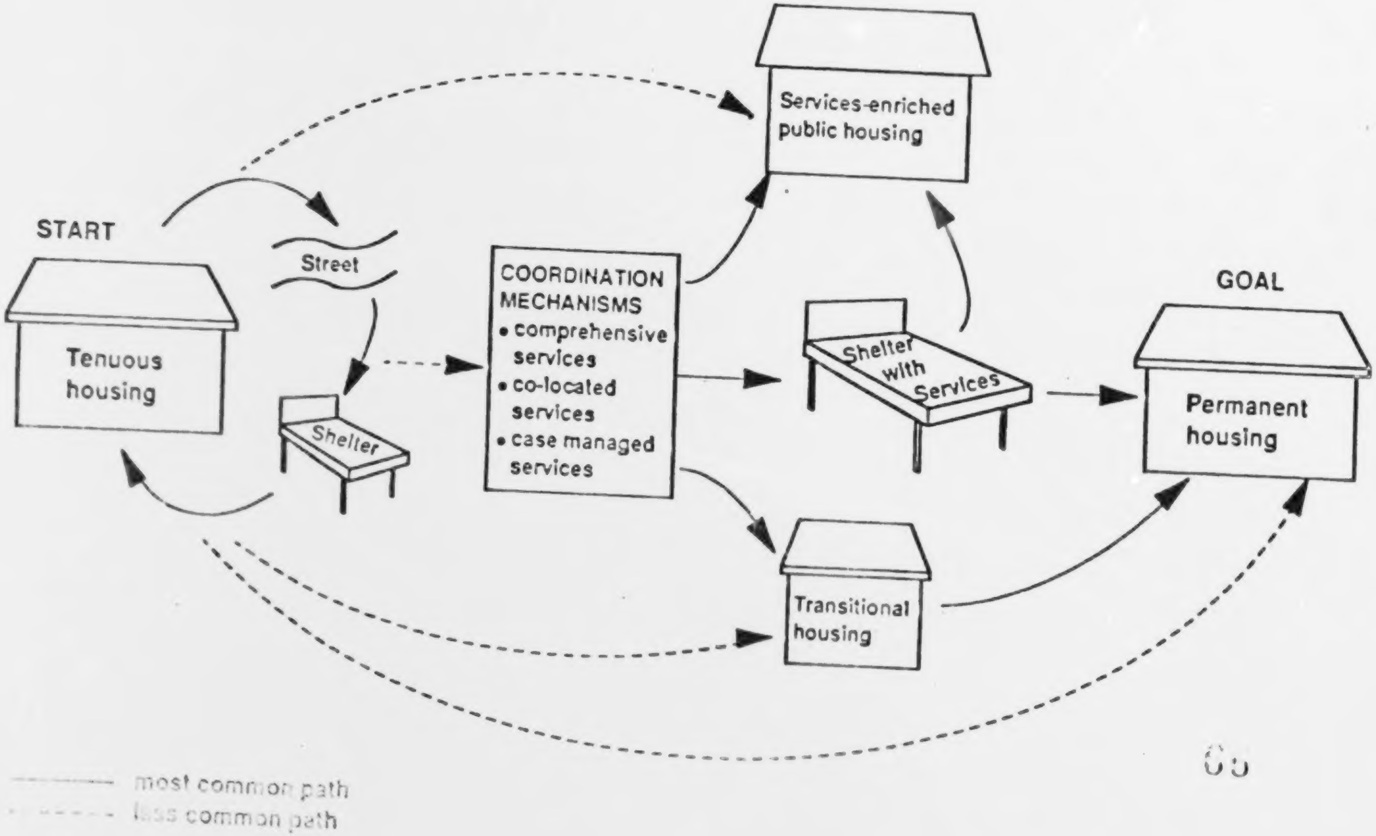
As an agenda for at-risk and homeless families, however, these efforts often fell short. Part of the problem relates to the multiple needs of homeless families and the fragmented service delivery system. Although, increasingly, providers recognize the centrality of the family's needs, efforts to provide services remain bound by the structures and strictures of existing programs. As a result, housing, health care, child care, substance abuse, employment, and education are often addressed in piecemeal fashion, rather than as a coherent whole. Exhibit 3 illustrates the flow of homeless families through the homeless service system. Without coordination efforts at the agency, provider, and family level, families either fall through the cracks in the system or have limited access to services.

The following six findings are the overall service coordination findings. They are discussed in more detail, with subfindings, in the discussion which follows.

- At the public agency level, there is very little coordination in dealing with the problems of homeless families.
- At the provider level, every city has one or more coordinating mechanisms.
- Although cities have many sources for information and referral to services, there is very little integrated service delivery.
- Coordinated and comprehensive case management is a major gap in the service system for homeless families.
- Lack of followup is a major problem in the service system.
- Evaluation of programs is currently not done, and would be difficult to accomplish.

EXHIBIT 3

FLOW OF HOMELESS FAMILIES THROUGH HOMELESS SERVICE SYSTEM



The remainder of this chapter discusses these findings in detail.

I. At the public agency level, there is very little coordination in dealing with the problems of homeless families.

An array of public agencies--State, county and city--have a potential role in providing services for homeless families. Especially important to the needs of homeless families are the coordination at the agency level of social services, housing, and income maintenance programs in a manner that will increase access for this population. The team found that all of these links are lacking to various degrees in all five cities visited.

The link between housing and social services is uniformly weak for homeless families, as it is for all low-income people. With the exception of some innovative efforts in Baltimore's public housing projects, the team found no effort to link housing and social services once homeless families leave the emergency shelter and THP systems.

Part of the lack of housing-social service efforts results from differences in the two agencies involved. Housing and social service agencies differ in expressed purpose, target population, the way services are allocated, and the level of government responsible for providing the service. Housing has traditionally been Federally funded and locally administered, usually by city or quasi-city public housing authorities, although States have recently become more heavily involved. Social services are typically funded through block grants to States or, for the major entitlement programs, through a combination of Federal and State funds. They may be administered at the State or county level, depending upon the State.

Local housing authorities tend to see their role primarily as landlords and housing is allocated on a first-come, first-served basis to a target population that is quite broad. By contrast, key social services are typically entitlements; anyone meeting the specified eligibility requirements receives services and social service caseworkers see themselves as having broader involvement in the lives of their clients. These differences in perspective sometimes make it difficult for these two agencies to undertake joint efforts.

Baltimore has a more integrated view of housing and social services than the other cities visited. The key factor responsible for this difference was the consolidation of the Housing Department, the Housing Authority and the Office of Employment Development (OED) into one agency--the Neighborhood Progress Administration (NPA). As a result, Baltimore's housing authority, unlike other cities, includes functions that extend beyond housing to include planning and community development. Although the OED has since been made a separate department, the enormous amount of resources within the NPA are able to serve the larger agenda of overall neighborhood economic development and community planning. It has not fallen into the landlord mode of operation that is characteristic of other cities.

Some of the innovative efforts to enhance housing and social services linkages, developed under the NPA, include the Family Development Centers and Family Support Centers. These models provide integrated support services and case management for residents in selected public housing projects. In addition, a private organization operates a network of Family Support Centers in several of Baltimore's low-income neighborhoods.

Although coordinating services between agencies such as housing and social services is difficult, the site visit team found that even within county social services agencies, coordination is not well-developed. In general, the site visit team found few links between social service departments and economic assistance departments. Part of this is an outgrowth of the late 1970s movement to recognize welfare as predominantly an income issue and to bifurcate the welfare function into a financial/eligibility worker track and a social services track for that portion of the population that needed additional services. However, over time, social services have become "categorized" and are only available to those that fit a niche such as child protective services, adult protection, or mental health. Those in need of general social services--and many multi-problem homeless families fall into this group--find themselves closed out.

Given the complex array of government agencies with potential roles in serving homeless families, the team expected to find a public office or agency that assumed a designated coordinator role. Few of the local governments had one. In Atlanta, the Homeless Services Coordinator is a city position and oversees mainly the city's financial contribution to homeless services. This position has little authority over the operations of other city agencies. In Baltimore and Oakland, the coordinator role has more prominence and is seen as a convener of agency officials; but neither has line authority over other agencies. Minneapolis and Boston have no position in local government coordinating efforts. As discussed in the next finding, the advocacy community has generally assumed responsibility to coordinate the efforts and to bring, to as great a degree as possible, government agencies into the effort.

The wide disparity in levels of involvement and levels of coordination of services for homeless families is due, in part, to the funding sources for these services. Federal funds supporting the direct service system come in a variety of streams. Some funding--FEMA and some demonstration grants--comes directly to the provider; other funding goes directly to local government; others to the State which then allocates to the county and providers. The patchwork of funding means that there is often no one level of government with an authoritative role.

AFDC is the economic linchpin for most families. As a Federal-State funded program, AFDC gives the State, and the county social services department in States where counties administer social services, more prominent roles in homeless family services than they typically assume in homeless single adult services. Conversely, cities--which are often key actors in funding and developing single adult homeless services--are not very active in the family system.

This interplay of State, county, and city roles varies in each city. In Boston, the State is key and the city concentrates on single adult homelessness. City services are only peripherally related to service delivery to families. In Baltimore, the city is very active, mainly because the city, under law, is a separate political entity equivalent to a county which removes a layer of government and simplifies jurisdictional issues experienced by other cities. The City of Atlanta includes portions of the State's two largest counties. While social services are under a State agency, administration is left to the discretion of the counties and the service system for both low-income and homeless families differs depending on the county.

II. At the service provider level, every city has one or more coordinating mechanisms such as a coalition or task force. Although public agencies may participate actively in these, the coordinating bodies are usually provider- or advocate-driven.

A strong coalition of service providers contributes to a coordinated service system and offers a vehicle to ensure collaboration and cooperation in providing services. Such a coalition can be helpful in obtaining and allocating resources and in enhancing advocate, provider, and government relationships. Coalitions also can play a major role in assessing needs.

Each of the five cities visited has one or more visible coordinating/advocacy bodies such as coalitions or task forces, although Baltimore is the only city that has an advocacy body specifically addressing issues of family homelessness.

The coalitions/task forces within the five cities differ widely in power, credibility, and breadth of participation. The broadest participation appears to be in Atlanta where the Task Force for the Homeless includes government officials as well as providers and advocates and where the city, county, and State are among the sources of funding. Informants indicated that the breadth of participation lends additional credibility to Task Force pronouncements and data--their input is beginning to be accepted as research data and not "advocacy numbers." The Task Force has also successfully integrated advocates and providers; in some other cities these have tended to develop separate professional organizations.

In Baltimore, the Coalition for Homeless Families and Children was singled out as the most significant reason for attracting foundation money on family issues. Funders have viewed it as a united front and as evidence of provider cooperation. Informants also indicated that the coalition has been effective in offsetting potential competition for scarce resources by reaching a consensus on which provider is the best candidate for providing the service. The degree to which individual providers have joined together and subsumed their own interests in the interests of the coalition is a compelling endorsement of the coalition in Baltimore.

In Oakland, the Emergency Services Network, a coalition of over 120 service providers, including government officials, has a contract with the city to provide a count and composite profile of the homeless in the county. In addition, providers meet on a monthly basis to plan for homeless service resource development and to agree on the most effective means for distributing scarce resources. The Network and the generally close working relationship between homeless service providers are considered key factors in the county's success in obtaining government and foundation grants and in packaging services in a more comprehensive manner.

In Minneapolis and Boston, the State coalitions for the homeless are the major advocacy organizations. Since both of these cities fund shelters from Federal-State AFDC-EA funds, State level advocacy takes on even more importance than in other cities. In Boston, there is also a separate statewide shelter providers association.

III. Although cities offer many sources of information and referral to services, there is very little integrated delivery of services through mechanisms such as one-stop shopping.

In all cities visited, homeless families have several sources of information and referral--including shelters, soup kitchens, day shelters, health care providers, and education providers. A plethora of resource guides and posted information exist. In addition, almost all the cities visited have a hotline that maintains up-to-date listings of shelters and other sources, although in only one city does the hotline provide information on shelter vacancies.

However, the site visit team found few examples of integrated services delivery in the five cities visited. Because homelessness is characterized by logistical obstacles that make it difficult for families to get to, wait for, or continue to receive mainstream services, some advocates and providers favor "one-stop shopping" to make services more convenient. While the site visit team found several instances of "one-stop shopping" for enrolling for services, less common among the five cities were locations where homeless families can actually receive multiple services.

Minneapolis came closest to a one-stop shopping model with on-site health, developmental screening, and legal clinics, and on-site enrollment for Head Start and mainstream schools. In Minneapolis, such arrangements are made easier by the relatively small size of the homeless family population, and the emergency shelter system, and because a single large family shelter houses about 85 percent of all homeless families.

In Oakland, two types of one-stop shopping sites will soon be underway. With earthquake relief funds from the 1989 Loma Prieta earthquake, the county and city are building a large multi-service center for homeless individuals and families in downtown Oakland. Transitional housing will be attached. Also, the Robert Wood Johnson (RWJ)-funded Oakland Homeless Families Program will operate two, small, community service centers which will serve as the central service delivery site for the families participating in the program.

In most of the cities, entitlements and housing services are rarely represented in the services delivered on-site. While many counties send information and referral workers to shelters, the site visit team found few places where the workers are able to take applications on-site for AFDC, food stamps, and WIC. Lack of intake staff was typically cited as the reason.

Housing assistance is an even bigger gap. In no city is the public housing authority actively doing outreach in shelters; even housing search assistance is uncommon as a shelter service. In Atlanta, the Homeless Families with Children program does offer considerable assistance with resettlement to families in shelters in Fulton County. In Boston, the State reimburses shelters for a housing counselor position and also funds a network of housing counselors around the State. The specific roles and responsibilities of these positions are left to the discretion of the providers so the services provided differ widely from shelter to shelter; however, they generally involve assistance with applications for public housing and looking for affordable private housing.

IV. Coordinated and comprehensive services planning, such as case management, is a major gap in the service system for homeless families.

Case management has evolved as a response to the needs of multi-problem clients who are forced to navigate the fragmented health and human services delivery system. Definitions of case management are diverse but share the common theme of providing a mechanism for ensuring that clients are provided the range of services needed in a coordinated, effective, and efficient manner. In addition, case managers often act as advocates on behalf of the client.

Because homeless families may need services from diverse agencies, and because co-location of services is not common, case management can provide an important coordinating service for homeless families. While the team found that case management for homeless families is provided to varying degrees within all of the cities visited, for the most part it is haphazard, overlapping, and not comprehensive in its coverage. While the public social services system might be expected to include case management as one of its functions, the site visit team found that government agency case managers are available only when homeless people fit a traditional social services category such as child protective services (CPS) or adult protection. Even then, persons fitting these categories may receive some services planning by virtue of their status as CPS cases or mental health cases, not by virtue of being homeless, and several of the cities visited reported that even for those families under the CPS system, caseloads are generally so large that very little case management is provided.

While almost all homeless families are eligible for, and most are receiving, AFDC, in the five States visited the role of the AFDC worker has been reduced to checking financial eligibility and few workers are in a position to do services planning much less active case management. Consequently, case management for homeless families has generally been assumed by nongovernment providers that have chosen to extend their service roles to include case management. The quality of case management for families is a function of the provider from whom the family receives services. In Boston, for example, shelter duration tends to be 90 days, and the lack of housing options means that most families stay almost for the full duration. Although a Family Life Advocate is a State-reimbursable position established at each shelter, they are not technically case managers and their duties vary from shelter to shelter. But some advocates assume those functions and the larger more prominent shelters supplement their efforts with additional services funded through philanthropy.

In Baltimore, the shelter system generally offers few services and almost no case management; the exception is the YWCA shelter which has a program of long duration and offers many on-site and referral resources. The quality of services received by families lucky enough to be placed at the YWCA is considerably better than those received by families placed at other shelters. And, understandably, there is a pattern of movement from other shelters to the YWCA by families.

In Oakland, the largest nongovernment provider of homeless services, Berkeley Oakland Support Services (BOSS), provides centralized case management services to all families entering the BOSS network of services. Because BOSS provides a wide range of services from drop-in, to emergency shelter, to transitional housing, to numerous support services, the program is able to follow and track families within its service continuum. Other nongovernmental providers in the county are not able to do this. They are only able to provide case management services while clients are being served by their own particular service or program; once clients leave, case management services end.

In most of the cities, the Health Care for the Homeless (HCH) program stands out as the most aggressive case managing organization--not júst in health care, but in planning all services. In part, the interest of the HCH programs evolves from their legislative mandate which includes assistance with social services and permits (but does not require) followup of clients for up to one year. The problem is that not all homeless families see HCH providers; those that need health care happen fortuitously to receive case management as a fringe benefit if they seek health care through HCH.

The site visit team found some well-developed models of coordinated case management among housed low-income families; these efforts are serving target populations very similar to homeless families. For example, in several of the States visited, the local version of the Federal JOBS welfare program is based on assigning an intensive case manager to each client. The case manager's role is to remove obstacles to self-sufficiency by identifying and coordinating services such as training, child care, housing assistance, health care and other needs. Some of the former Project Self-Sufficiency programs used a similar model.

Among the nine newly-funded Robert Wood Johnson (RWJ) Homeless Family Program demonstration grants are several for which comprehensive case management is the central component of the program. For example, in Baltimore the RWJ program will adapt the intensive case manager approach of the State's JOBS model to the needs of the participating homeless families. In Atlanta, the participating homeless families will be housed in neighborhood clusters and each cluster will be assigned a coordinator. In Oakland, case management is the centerpiece of the Oakland Homeless Families Program. Each family will meet with a case manager after completing the initial intake and assessment process; the case manager then develops an ongoing caseplan with the family.

Two final points about case management emerged from the site visits. First, even when there is case management, it is mostly social services that are coordinated. Housing tends to be left out. Case management for homeless families is provided by human services personnel who have few housing resources to offer. Consequently, support services for families may be exceptionally well coordinated, yet the family may still be homeless.

Second, some advocates interviewed object to the premise that case management is needed. For some, case management is being touted as a panacea; it assumes that all that is needed to transform families is *linkages* to services, rather than improved services. Others object on philosophical grounds, contending that the service system should not take on a caretaking role. Said one, "Why should we call them cases and why would we want to manage them?" In this view, most families need only housing and do not need nor want the intensive case management that is a prerequisite for program participation by some providers--particularly if it cannot offer housing.

V. Lack of followup of homeless families once they leave the service system is a major problem.

Followup services are closely linked to case management and may be viewed as an extension of case management services. In particular, followup is considered a key way to address recidivism. As with case management, the lack of followup was cited by informants in each city as a major problem. Even programs that offer case management are not able to do followup. Only a few programs are monitoring clients once they leave the program. While there are many reasons for this, such as shortage of funds and a focus on the immediate need, attempts at followup are also confounded by the fact that families do not want to be followed. Especially at the emergency shelter level, families see their homelessness as transitory and unpleasant; they do not want the stigma of having been homeless and wish to leave shelters as soon as possible. Since emergency shelter is often of short duration, many families do not develop the strong ties to staff or other families which would incline them to keep in contact; most programs reported that families leave suddenly and without prior notice. Few programs are able to enforce a forwarding address requirement.

Although it is especially prevalent at the emergency shelter level where resources for this function are scarce, lack of followup confounds the best intentions of even those programs that undertake it as a mandate. Health Care for the Homeless programs, for example, are permitted to devote resources to followup for up to a year after the client leaves the program. Yet even in Minneapolis, where the HCH program is part of the county and thus has access to county client records for welfare and other programs, staff estimate that they lose track of about half of the clients. Even clients they do follow are frequently soon lost. Anecdotal evidence suggests that families move frequently--either in and out of homelessness or from one substandard accommodation to another.

In those instances where followup is occurring and working, the key factors seem to be duration of the program and intensity of services. THPs seemed to be most successful at followup. Typically, THP clients are voluntary participants, stay in the program for several months, receive an array of services, and are likely to develop ties to staff and other participants.

VI. Outcome evaluation of programs for homeless families is rarely done and would be difficult to accomplish.

Outcome evaluation is essential in identifying effective service approaches; however, there were almost no instances of outcome evaluation in any of the five cities. Many programs were not tracking even basic client data. Several factors inhibit evaluation of homeless services:

- Lack of followup. As described above, most programs lose track of families once they leave the program. This makes tracking short-term or long-term outcomes impossible.

- Lack of clarity about program goals. Is the goal of the program to find housing? Few shelters have the capability to do that. Is it to stabilize families? How would that be measured and what can be expected to occur in the short duration of most families' homelessness?

- Inability to attribute successful outcomes to services. Homelessness is clearly both structural and personal. While a program can provide job training, it cannot ensure employment in a weak local economy. Likewise, while shelters can provide stabilization services so families can maintain independent living, these are of little use in a housing market with no affordable housing. Most informants indicated that their programs had far less effect on the fate of their clients than did fluctuations in the economy.

As with followup, programs that are able to do evaluation tend to be those with long durations such as transitional housing programs. The clients are more likely to develop an identification with the program and the program is more likely to be providing extensive services to the client and to have set goals for the services. Nevertheless, many transitional housing projects had not conducted outcome evaluations.

Chapter VI

Cross-Site Findings:
Comprehensiveness of Services

The poor tend to suffer a disproportionate share of social ills--family breakdown, teen pregnancies, inadequate housing, ill health, drug and alcohol abuse, child and spouse abuse, juvenile delinquency, and involvement as either victims or perpetrators of crime. Female-headed families are even more likely to experience these problems. Together, these problems impede a family's chance for self-sufficiency.

Homeless families share these problems, with the addition of another, lack of housing. As a result of their multiple problems, in order to be self-sufficient, homeless families require a service system that is not only coordinated, but comprehensive as well. In addition to housing, homeless families often need to be linked to such diverse services as public assistance, health care, education, job training, life skills training, parenting training, substance abuse counseling and treatment, child care, transportation, and programs that address the social, emotional, and educational needs of children (e.g. Head Start). Exhibit 4 illustrates some of their relationships. Most of these programs exist in the mainstream service system; some have developed to meet the particular needs of homeless families.

The following 13 findings from the five sites visited concern the comprehensiveness of the service delivery system in the five cities visited across the many different program areas that affect homeless families with children:

- Cities do not have a true housing continuum in place that includes emergency shelter, transitional housing, and services-enriched permanent housing. Either they lack one of these service pieces or these services do not have the capacity to meet the demand.

- The links between the various pieces of the housing continuum are either weak or nonexistent. As a result, homeless families are often left to navigate the system on their own and may not receive the amount and degree of services they need.

- Support services for homeless families are often provided in an inappropriate setting within the housing continuum.

- Health care is typically provided by programs set up specifically to serve homeless individuals and families.

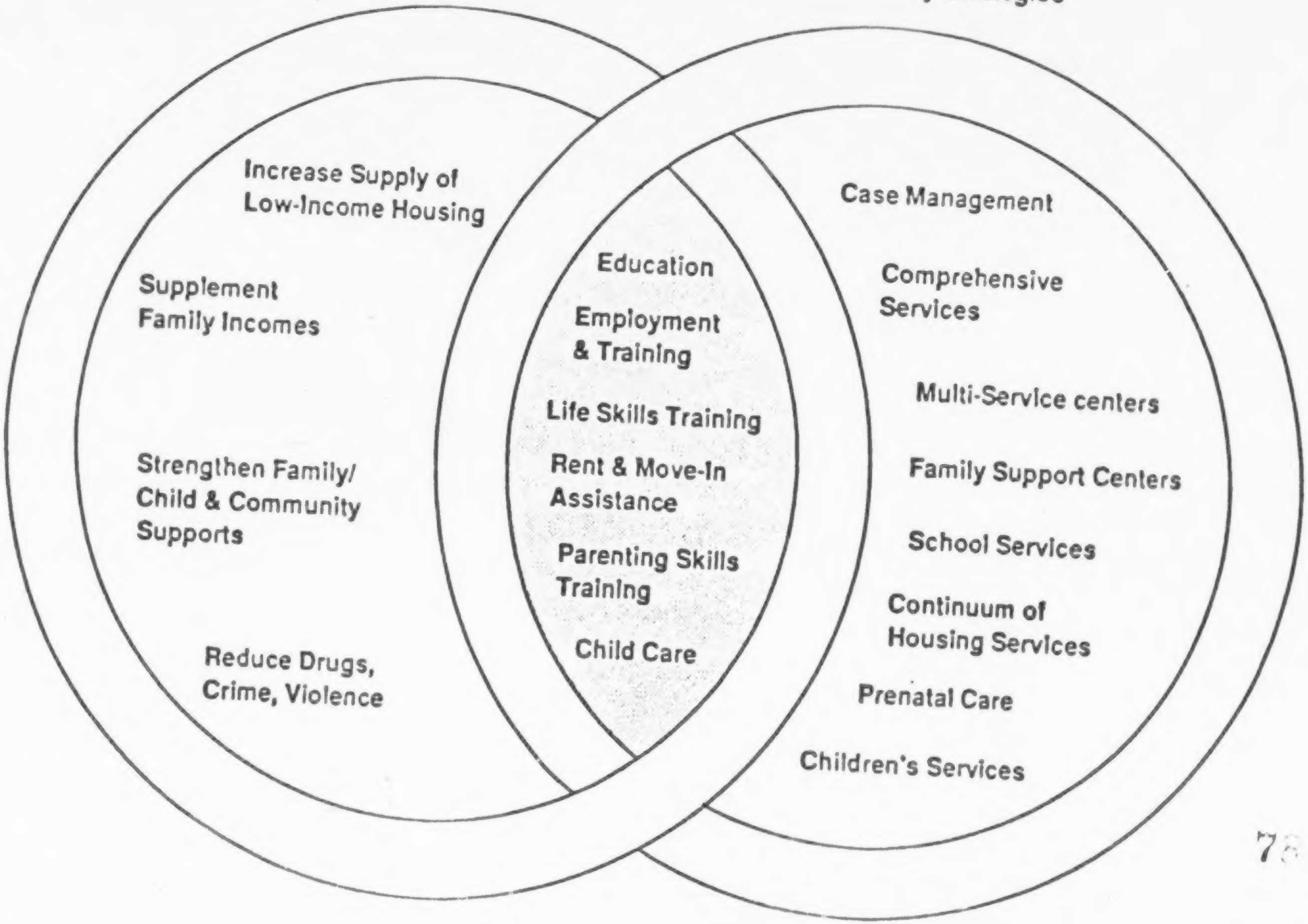
- The McKinney Act has greatly improved homeless school-age children's access to the public school system.

- Preschool programs, including Head Start, are not serving the majority of homeless preschool-age children.

- Links to employment and employment and training programs are weak; homeless adult family members rarely benefit from these programs.

EXHIBIT 4

LONG-TERM AND PREVENTION STRATEGIES FOR AT-RISK AND HOMELESS FAMILIES



At-Risk Family Prevention Strategies

Homeless Family Strategies

Increase Supply of Low-Income Housing

Supplement Family Incomes

Strengthen Family/ Child & Community Supports

Reduce Drugs, Crime, Violence

Education

Employment & Training

Life Skills Training

Rent & Move-In Assistance

Parenting Skills Training

Child Care

Case Management

Comprehensive Services

Multi-Service centers

Family Support Centers

School Services

Continuum of Housing Services

Prenatal Care

Children's Services

- Lack of adequate child care is one of the most frequently cited obstacles to independent living for homeless families.
- Emergency shelter is not the best site for providing long-range services--clients are disoriented, transitory, and in a state of crisis.
- Homelessness does not constitute *de facto* environmental neglect, but does have implications for child protective services involvement and reunification of families.
- Links to WIC and to the major entitlement and discretionary programs such as AFDC, Medical Assistance, and food stamps, are in place for homeless families.
- Demand exceeds supply for all types of substance abuse treatment.
- Battered women are often counted as part of the homeless family caseload, but the links between the two service systems are not strong or visible.

The remainder of this chapter presents a detailed discussion of each of these findings.

I. Housing

A. Although housing services are often conceptualized as a continuum, the cities visited do not have a true housing continuum in place that includes emergency shelter, transitional housing, and services-enriched permanent housing. Usually one or more of the components of the continuum are either missing or suffer from inadequate capacity to meet the demand.

1. Cities are trying to create a housing continuum.

In all five cities, various programs have been designed specifically to meet the housing needs of poor and near-poor individuals and families. However, it is widely believed that in order to meet the diverse needs of homeless families, communities need to develop a continuum of housing assistance that includes emergency shelters, transitional housing programs, and services-enriched permanent housing.

Although each of the five cities visited used the term "continuum" to refer to the ideal housing services system, few cities have a true housing continuum in place. Some cities have a strong emergency shelter system with linkages to a variety of services or with services provided on-site. Others have innovative transitional housing programs, a few have examples of services-enriched public housing. No one city has adequate services at all levels of the continuum.

2. **All cities are struggling with the inability to meet the demand for services in those pieces of the continuum that are in place.**

Emergency shelter. Most of the five cities reported that families are being turned away from emergency shelter. The frequency with which families are turned away varies. At one extreme, in Oakland over 70 percent of all requests for shelter (family and individual) are denied; the overwhelming majority of these turnaways are due to inadequate shelter capacity. In Baltimore, the YWCA shelter indicated that it turned away 400 to 500 families each year. In Boston, shelter overflow is accommodated by using hotel and motel vouchers; however, these settings are even less desirable than emergency shelters because they do not provide any services.

In addition to turnaways because of lack of space, certain types of families are commonly excluded from the shelter system due to shelter program limitations. While no city was routinely unable to accommodate specific types of families, intact families, families with older male children, large families, and families with active substance abuse problems have difficulty accessing the shelter system.[73] Adolescent and adult males, for example, are typically excluded from shelters with communal living space on the grounds that their presence will exacerbate the lack of privacy for women and children. Even those shelters where families are housed in apartments or suites may exclude males because the neighborhood opposes their presence, or more frequently, because the shelters feel that their presence disrupts the chemistry of the shelter community or exposes women and children to danger, especially in programs which draw participants who have been victims of domestic violence. This fear is not always justified; the study team noted that those shelters accepting adolescent males do not appear to have these problems, including several shelters with communal living spaces.

Transitional housing. Most of the cities expressed an interest in developing additional programs to bridge the gap between emergency shelter and permanent housing. These programs, called transitional housing, are often small and offer more intensive services over a longer period of time than do shelters. However, in part because of these characteristics, transitional housing programs usually operate at capacity and are able to serve only a small percentage of the demand for services.

Affordable permanent housing. The high cost of housing combined with inadequate family income has led to an acute shortage of affordable housing in each of the five cities visited. Even advocates that emphasize the role of individual factors in family homelessness agree that affordable housing is a major gap. The inadequacy of public housing is compounding this problem dramatically. Families often face a wait of several years before receiving either Section 8 rental assistance or entrance to public housing. In Oakland, the wait for a three-bedroom unit in either Section 8 or public housing averages five years. In Atlanta, the wait for public housing is relatively short; however, Section 8-assisted housing is extremely scarce. Baltimore housing officials indicated that the wait for public housing is very long unless the family is willing to live in one of the large, high-rise public housing projects which tend to have drug and violence problems. In many cases, when families do acquire private housing, informants indicate that it is substandard.

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[73] Older male is typically defined by shelters as any male child older than 12 years, but cutoffs as young as 8 years old were found in some shelters.

Services-enriched housing. There is also a shortage of services-enriched housing--permanent housing within the community with various services linked to the housing services. Advocates generally agree that a certain percentage of the homeless are in need of supportive services in addition to housing. While transitional housing is often controversial because it is another step before a family receives permanent housing, services-enriched housing places families into stable housing with the necessary supports to allow families to live independently. Yet, such services-enriched housing is not common in the cities visited. Minneapolis is an exception; there the predominant transitional housing approach has come to resemble services-enriched housing for homeless families. Another well-developed model of services-enriched housing is found in Baltimore, where two public housing high-rises are offering comprehensive services to tenants in Family Development Centers and Family Support Centers.

B. Even when the components of the housing continuum are in place, the links between the various components are often either weak or nonexistent. As a result, homeless families are often left to navigate the system on their own and may not receive the amount and degree of services they need to move through the continuum successfully.

1. Shelter intake is still mostly self-referral.

All five cities have some type of informal information and referral system (I&R) allowing families to learn about shelter space availability in I&R participating shelters. In general, families contact shelters directly or contact the I&Rs to determine if shelter space is available. They are on their own after this point to access the shelter, if space is available. In three of the five cities, self-referral was the major mode of referral to shelter and the only necessary step to receiving shelter services. While several cities reported that they are considering centralizing the shelter intake function to make access to shelter easier for families, these efforts appear to be weakly supported. Providers feel that the informal I&R networks operate effectively, and with shelter systems often operating at full capacity, a centralized I&R network would have nowhere to refer families and individuals.

Two of the cities, Minneapolis and Boston, have centralized the intake function. In both cases, the impetus for doing so was to track daily shelter attendance for AFDC-EA. In these two cities, while families are allowed to access shelter initially on their own, families must be screened and declared eligible by the government agency responsible for shelter vouchers, the county

Department of Economic Assistance in Minneapolis, and the local office of the State Department of Public Welfare in Boston.

Theoretically, centralized intake would make data collection easier and more accurate, taking this responsibility out of the hands of overburdened providers. More importantly, centralized intake would provide the infrastructure for centralized needs assessment and case management. Case workers could--and in Minneapolis do--screen families applying for vouchers for major entitlements and social services. However, informants indicate that such screening is still perfunctory and it did not appear to the project team that the public agency role in linking people to services was operating more smoothly in Minneapolis because of the centralized intake function.

2. Shelter stays are often short and families tend to "disappear" when they leave shelter.

Families who enter the shelter system are often in crisis. According to shelter providers, the main goal of these families is to obtain permanent housing as soon as possible. As a result, their stay in shelter is often short and abrupt. This may be both by necessity and by choice.

First, shelters differ in how long they allow families and individuals to receive shelter. In the two cities with centralized intake--Minneapolis and Boston--the voucher determines a suggested maximum stay of 30 days and 90 days, respectively. In the other three cities, the allowable shelter stay is set by individual shelters and can be as short as a few weeks or, far less commonly, as long as six to eight months.

Second, families tend to have an average length of stay (ALOS) that is far shorter than the duration of stay allowed. (The exception is Boston where ALOS was beginning to approach the 90 day voucher limit.) While providers believe there is a segment of the homeless family population that stays in the shelter system for a long time, moving from shelter to shelter, in general, the little data available seems to indicate that the majority of homeless families stay in shelter briefly. In Minneapolis, for example, the ALOS was 11 days while shelter voucher duration is 30 days.

When families leave, they often do so abruptly. Although several shelters reported that they ask families and individuals for forwarding addresses, the shelters find that many families do not comply or that their addresses are often inaccurate or are not accurate for long. Families often do not want to be contacted by shelters and may move frequently after leaving shelter.

3. Transitional housing is rarely linked to emergency shelters.

While advocates assert that many homeless families need only affordable housing, all clearly recognize that a certain portion of the homeless family population needs more support than is currently available in emergency shelters to maintain independent living. Clearly, the transitional housing program model is a viable one for providing that type of support. Yet, the team found that THPs are generally not well linked to the shelter system and tend to draw their participants from populations other than the shelter population.

There appear to be two major reasons why the shelter/THP link is weak: First, links between transitional housing and shelter are hard to make because of the sporadic nature of THP openings. THPs typically allow much longer stays than emergency shelters. THPs rarely maintain waiting lists for their programs because their participants are in the program for anywhere from a few months to 2 years, and because the capacity of their programs is often small. Consequently, although families in emergency shelter might benefit from THP services, seldom will an opening occur just as they are completing their shelter stay. Second, THPs tend to "cream" the homeless population for their clients, serving those with the greatest motivation and goal orientation. Program staff indicate that the shelter population tends to be more multi-problem than the THP population. While it seems inconsistent that the more intensive setting should be addressing the less troubled population, THP staff believe that their program will only work for those motivated to change and willing to enter into and abide by service contracts. THP providers indicate that many sheltered families would not pass the screening for a THP even if openings were available.

4. Links to permanent housing--both public and private--are not adequate.

Because rents are escalating and subsidized housing is in short supply, when families leave shelters or transitional housing, advocates believe that they are often housed tenuously. In the long run, providers and advocates believe that this contributes to a repetitive cycle of individual and family homelessness. Again, no hard data are available.

The project team found that public housing authorities, which manage Section 8 certificates and public housing units in cities or counties, are typically not an active participant in the homeless service system. This is both because of the short supply of housing assistance available and the traditional focus of these agencies. Housing authorities have a limited number of Section 8 certificates (the option most families prefer) and housing units that they are required to distribute based on established Federal and local preferences. Federal preferences offer priority to displaced families, families in substandard housing, and those paying more than 50 percent of their income towards housing. The more preference categories a family meets, the more likely the family will receive an apartment or certificate. Local preferences are also in effect.

In practice, these preference systems vary. Housing authorities may weigh one preference more highly or all of them equally. The substandard housing preference incorporates the McKinney Act definition of homelessness. However, the homeless do not automatically receive public housing because substandard housing is only one of several housing preferences and is not always the highest priority preference. In addition, because waiting lists are so long, even those given preferences may face very long waits.

The few cities with preferences for homeless families find that the preferences are effective in assisting homeless families. In Atlanta, preferences have reduced the waiting time for public housing from several months to a few weeks. In Baltimore, a small number of Section 8 certificates are reserved for families in the Transitional Housing Program; in Oakland, participants in the RWJ Homeless Families program will receive priority access to Section 8 certificates.

In general, however, most homeless families have a different experience. In Boston, where public housing preferences rest with each of the 250 local authorities, one source estimated that only 2 percent of homeless families access public housing. In many of the cities, homeless families face 3- to 5-year waiting lists for assistance for Section 8 certificates, especially for apartments with more than two bedrooms.

Part of the problem lays with the traditional focus of Housing Authorities. They tend to operate as landlords distributing financial assistance and commodities, rather than comprehensive service providers. They are not usually active in innovative housing/support services collaborations or in helping families with housing searches. As was discussed earlier, an exception to this rule is Baltimore, where the housing authority is part of the city government rather than a separate quasi-government agency, as it is in most cities. In the other cities, when assistance with housing search is provided, it is provided by nonprofit organizations or by social service agencies.

Finally, it should be noted that public housing, while permanent, is not an ideal situation for many homeless families. Vacancies typically occur in the least desirable projects and families who are already unstable and have few personal resources are not likely to thrive in this environment. Nevertheless, for a family supported by AFDC it is likely the only feasible way to maintain housing costs at 30 percent of income. Although it is often preferred by families, Section 8 assistance is far less likely to be the housing option for homeless families because so few certificates and vouchers are available.

C. Support services for homeless families are often provided in an inappropriate setting within the housing continuum. In particular, long-term services are often concentrated in emergency shelter where families are likely to remain for only a brief time.

In general, shelters provide a safety net of shelter, food, and health assessment and income stabilization services; transitional housing provides temporary housing and the support services necessary to achieve self-sufficiency; and permanent housing offers housing and in a very few instances, some support services. If these services were available and linked, families would receive the amount and degree of services they needed to live independently at the appropriate setting. As shown above, this theory breaks down because services are often not available or linked. Because of this, services are often provided in inappropriate settings.

1. **Emergency shelters are successfully providing "stabilization" services for homeless families. However, the viability of shelters providing longer term support services is questionable.**

The term "emergency shelter" encompasses a variety of models and types of programs in most cities in terms of duration and intensity of services. In some shelters, such as the Berkeley-Oakland Support Services' (BOSS) family shelter which serves Oakland families, families can remain in shelter for up to 6 to 8 months; during this time they are connected to a wide range of support services. But BOSS is an exception; the maximum stay in most shelters is closer to 30 or 60 days. This brief duration limits the types of services that can be offered. Other shelters are open only at night and require families to leave during the day. The services that can be offered in these types of shelters are even more limited.

In the five cities visited, the 24-hour emergency shelter is becoming the norm for serving homeless families. In all five cities, 24-hour shelters predominated. Even in those cities with many night-only shelters, such as Oakland and Atlanta, there is a move toward 24-hour shelter as a goal. The main motivation for this move is to provide a more stable environment for families. Vacating the shelter each morning, especially without child care options is both disruptive and disorienting.

While the intensity of services in some shelters is quite high, especially those with long durations, most shelters act as "way stations" while people get their bearings. As one informant noted, their shelter's main function was to provide families with a place to stay while they wait for their AFDC eligibility to clear and for their application for public housing to be approved. Indeed, in cities where homeless people are accorded preference for public housing, shelters frequently serve as little more than waiting rooms for the housing authority.

Given the brief period of time most families are in emergency shelter, many feel it makes little sense to inundate them with services during this time. Life skills, parenting skills, and similar activities are often parts of the shelter service plan. Yet families in shelter are in crisis and are rarely receptive to such services. One provider noted that mothers would not actively participate in any programming that was not related to housing. Given the short duration of their stay, it is unlikely that individual factors related to homelessness can be resolved in such a short period of time. Instead, shelters can serve a more important function by introducing families to targeted or mainstream health and social services that they can continue to use upon leaving the shelter. In other words, shelters serve as arenas for programs to conduct casefinding or outreach to bring high-risk populations into care. While some shelters perform this function by linking families to entitlements and health and social services, many do not. And the mainstream agencies themselves typically do not perform outreach to the shelter system even though it is a captive audience of eligible potential clients. The key reason given is lack of funds to out-station employees. In addition, for mainstream services such as Head Start, developmental services, and many health care services, demand by eligible people already exceeds capacity.

2. **For those families in need of support services in addition to permanent housing, THPs can play an important role. However, advocates believe that for many families THP is simply another "hoop" to clear before families receive permanent housing.**

THPs are often the most innovative and varied of the options on the housing continuum. While in the past THPs served primarily the deinstitutionalized chronically mentally ill or others in need of a "halfway" housing setting, a growing number of nonprofit organizations have established THPs for homeless families. While, the growth in THPs reflects the recognition that many families have long-term, unmet needs that cannot be addressed adequately in emergency shelters, it also reflects the worsening of the low-income housing crisis, and the relative unavailability or inaccessibility of mainstream health and social services (such as drug treatment).

The study team found that THPs were far more likely than other programs to have undertaken outcome evaluations; several of those visited indicated high rates of success in terms of participants maintaining independent housing after departure from the program. However, several concerns were raised about THPs:

- Although THPs permit maximum stays of 18 months to 24 months, participants typically stay for a far shorter time. How much is realistically accomplished in terms of reorienting goals and conveying education, job, and other life skills in a few months?
- Many participants leave THPs early because they acquire Section 8 certificates, especially in cities where participation in self-sufficiency programs accords Section 8 preference. To what extent do THPs serve only to provide interim housing for families who could be independently housed if permanent housing were available? At what cost do THPs perform this role?
- In some cities, Section 8 certificates are reserved for THP participants. Advocates express the concern that THPs are sought out by families not because of the support services offered but in order to get access to Section 8-assisted housing. Could these certificates be better used to provide access to permanent housing without requiring some

families to go through a superfluous and expensive step of transitional housing?

3. **In general, all services disappear once a homeless family becomes permanently housed, leaving the family at risk of becoming homeless again.**

The many support services directed at homeless families generally end once families leave shelter. Even when a provider is willing to continue to offer services to formerly homeless families, these efforts are rarely successful. There are two shelter-related reasons why this is so. First, a family's permanent housing may be too far away from the shelter to make participation in shelter services feasible. Second, after leaving shelters, families often do not want to have any contact with the shelter because of the stigma attached to having been homeless.

These reasons make it unlikely that families will return to shelters to receive services such as health care. And, these reasons lead advocates to stress the need for shelters and homeless service providers to link families to mainstream services while they are in shelter. However, it is also clear that many of the services often available in shelters, such as child care and health care, may be less available once families leave shelter. Homeless families are then just "low-income" families and face the same service access problems as other low-income families. The mainstream service system is often underfunded and unable to meet the demand for services on the part of low-income families, particularly for child-related services.

Services-enriched housing has been proposed as a logical and less costly alternative to providing families with a multitude of services in shelters or to providing transitional housing to families who are mainly looking for shelter.

One example of services-enriched housing is in Minneapolis. Elim Transitional Housing has gradually moved from scattered site transitional housing, in which the program rented units and the family moved on at program completion, to a rent subsidy model, in which the family finds a unit or retains its current housing and the program supplies both a rental subsidy and case coordinator to help the family identify and implement its goals and stay in the housing. This newer model was implemented largely because it is less expensive, puts more responsibility on the family to retain the housing, and is less disruptive to the family at program completion.

Baltimore's Family Development Center, which is located in one of the city's high-rise housing projects, and the Family Support Centers located in housing projects and low-income neighborhoods do not serve homeless families while they are homeless, they serve many formerly homeless families. As such, these housing projects operate as services-enriched housing. They provide, in the case of the Family Development Center, a series of formal programs and services such as education, GED, literacy, health care, and employment training backed up by subsidized child care, and in the case of the Family

Support Centers, more informal drop-in services and information and referral. Both types of centers help build informal support networks for low-income families who do not have these in place. The study team found that these programs were more common in Baltimore than in the other cities because the relevant agencies were all part of the city government or had strong links to the city government. Thus, the typical chasm between housing and social service agencies was bridged organizationally.

II. Health and Development Services

A. Health care is the service most commonly provided by programs set up specifically to serve homeless individuals and families.

1. Homeless advocates and providers feel that targeted services are necessary if homeless individuals and families are to receive needed health care services.

Advocates and providers in the five cities visited stressed that it is important not to duplicate services that are already available in the mainstream service delivery system. However, health care services stood out as the one service that was regularly targeted to homeless families.

The main reason offered for dedicating health services to the homeless is that the mainstream service system is not equipped to serve homeless families well. Informants explain that, in general, poor families have difficulty accessing traditional or mainstream health services because of financial, bureaucratic, programmatic, and individual obstacles. Poor families often face a lack of health insurance or other health care financing, a shrinking pool of providers willing to participate in Medicaid, complicated Medicaid application procedures, long waits for services or restricted clinic hours, inadequate transportation, and inhospitable conditions at clinics. In addition, poor families may not understand the importance of health care or may be unable to make it a priority.

Because they are both poor and in crisis due to their lack of housing, homeless families have even more difficulty coping with these obstacles. According to several informants, compared to finding housing, health care is rarely a priority for the homeless. When faced with long lines at clinics, little or no transportation, lack of child care, and a provider community that may be unwilling or unable to serve them, homeless individuals and families forego trying to access health care services. As a result, routine health care is often impossible for homeless families, and they end up not receiving the acute care services, ongoing services, preventive services, or health education they need. In the long run, particularly for children, this can become a costly omission.

With this situation in mind, homeless health care providers in the five cities are working to offer families services that are more accessible. The

McKinney-funded Health Care for the Homeless programs are providing services where homeless families tend to congregate. In each of the cities, except Baltimore, health care services are offered in shelters, parks, and drop-in service centers. Even in Baltimore, where the Health Care for the Homeless staff defined the program's purpose as breaking down the barriers in the mainstream system, the program operates a dedicated street clinic in the downtown area.

2. **The McKinney-funded Health Care for the Homeless (HCH) programs play an important role in communities by performing aggressive outreach to homeless families and by helping to coordinate the various health and social services homeless families need.**

In the five cities visited, Health Care for the Homeless programs are providing primary health care, preventive health care, and followup care services to homeless individuals and families.

In three of the cities, the Health Care for the Homeless programs are located administratively within county health departments or agencies; in one city HCH is located in a hospital; and one city operates HCH through a nonprofit, nongovernment cooperative agency. Because each city varies in the constellation of health services offered in the health care delivery system, the linkages that HCH makes to the mainstream system also vary. The study team found HCH programs offering outreach services at a variety of locations where homeless individuals and families congregate, providing services at shelter-based clinics, utilizing roving medical teams and mobile medical vans, and helping families get services in community-based and hospital clinics.

In addition to providing health care services, HCH staff often help families link up with other types of services. In most of the cities, HCH provides financial assistance by linking families to AFDC and Medicaid. The HCH team may also have a social worker who helps families locate housing and assists with move-in needs. Some of the most aggressive general case management takes place within HCH programs. In Minneapolis, HCH is the key case manager and provides up to a year of followup. In Atlanta, several demonstration grants allow the local HCH programs to provide very innovative case management for mentally ill and substance using homeless people. This case management is comprehensive and exists beyond health care needs to include housing, social services, and financial assistance.

Finally, HCH staff provide services specifically for pregnant and parenting women and young children. Staff offer women health education and refer pregnant women to prenatal care within the community. In some cases, HCH staff follow up to make sure these appointments are kept. Pregnant and parenting women are also referred to the WIC program. Infants are offered health examinations to assess growth and development and given immunizations and screenings for anemia and lead poisoning. Older children are offered physical examinations and growth and development assessments.

If more serious problems are uncovered, staff refer adults and children to appropriate services in the mainstream system.

3. **Several key health and development services gaps remain for homeless families with children.**

Health Care for the Homeless programs are able to provide comprehensive services to families in accessible locations while they are homeless. Several other programs such as community health centers, WIC, and Head Start also offer families health services, particularly screening and assessment services. However, when families are referred out to the mainstream system for services such as prenatal care, developmental services, and WIC, the continuity of care often breaks down. This occurs because of the various access obstacles outlined above such as transportation and child care problems and because homeless family members are not given priority in already overburdened service programs. Specifically, the study team found:

- Prenatal care and well-baby care are not well-developed services for homeless women.

- Few developmental services (beyond screening) are available in communities and homeless children often either are not eligible for services or do not receive priority.

- Access to WIC is limited either because homeless women must travel to the WIC agency to receive WIC vouchers or because they do not have refrigeration at shelters to maintain the milk and other perishable food. A demonstration project in Atlanta, which is discussed in more detail later, eases access to WIC by providing on-site certification and voucher distribution at shelters and by modifying the WIC food package to include nonperishable food and dairy products.

Finally, followup services are a key gap. Although Health Care for the Homeless programs attempt to keep in contact with families after they leave shelters, they seldom are able to do so. Families either do not leave forwarding addresses or are unwilling to return to service sites (such as shelters) that often have the negative stigma of homelessness attached to them.

III. Education

A. The McKinney Act education provisions have greatly improved homeless school-age children's access to the public school system and to the school that is in the best interest of the student.

1. Cities are responding to McKinney in both spirit and practice, but transportation is the key link.

The education provisions of the McKinney Act mandate a process for determining the school placement that is in the best interests of the child and for removing obstacles to access to the school that is in the child's best interests. In general, the project team found that improvements in access to mainstream education was one of the bright spots in the five city case studies. The provisions of the McKinney Act regarding access to education have been adopted in spirit and in principle in most of the cities visited. Few shelters report difficulties in enrolling homeless children in the local schools. Indeed, in one city, advocates believed that the local school was overzealous in accommodating homeless children before finding out if the child had been receiving special services that could better be provided in the school of origin.

Homeless children are given the option of attending the school which best serves the child's interest, whether that school is the child's school of origin, the school nearest the shelter, or the school near the child's future home. In all the cities visited, no policy precluded a sheltered child from remaining in the school of origin. However, transportation is the key link to make the child's and family's school preference work. McKinney does not require that transportation be provided to implement the access policy, nor does State law in most States require that transportation be provided outside of the local school attendance zone.

Nevertheless, in all but one of the cities visited, the sheltered child is encouraged to remain in the home school if desired and local school districts have elected to accommodate this by providing special transportation. In both Minneapolis and Boston, school desegregation and magnet school systems have required complex cross-city transportation systems which can easily accommodate transporting homeless children from the shelter to their home school. In Baltimore, the city school district has committed to keeping a child in the same school for the entire school year, and even provides taxis to transport children. In Oakland, the city school district is providing transportation to either the school of origin or to the school near the child's future home.

2. **The number of homeless school-age children attending school on a regular basis is increasing.**

In all of the cities visited, the number of homeless children attending school is increasing. Solving the transportation problems is generally credited with the improvement; indeed, it will be hard to increase the percentage much higher than it is. Lack of attendance is now most often due to the mother seeing homelessness as a temporary problem and not wanting to enroll the child or, in abusive situations, to fear of the abusive parent finding the child.

3. **Dedicated schools for homeless children are no longer very common.**

In general, advocates in all cities visited endorsed mainstreaming of homeless children in the school system and keeping the child in the school of origin. The team found only two examples of targeted education services. In Minneapolis, while homeless students from within the county continue to attend their school of origin without interruption, there are special shelter-based and magnet-school services for homeless students who have moved to Minneapolis from out of the county--about half the homeless student population. Shelter stay is so short that moving children from the local school to a new school after a few weeks was felt to be disruptive; the targeted programs allow the shelter and the school district to provide extra services to link the child to the mainstream school once the mother finds permanent housing. Oakland was an exception to this prevailing trend. In Oakland, advocates are considering a shelter-based school because the mainstream school system is not believed to be serving the emotional and educational needs of homeless children.

4. **Barriers to providing appropriate educational services to school-age children remain.**

Although access to the schools is working well, educational performance of homeless children is still a problem. The stress of shelter life and the transient nature of homeless families often negatively affect the child's academic performance. There were few school-based examples of efforts to address the special needs of homeless students, although most shelters were offering opportunities for children to do remedial work, such as tutoring.

One side effect of the commitment by school districts to maintain homeless students in their school of origin is that teachers and school personnel may not know which children are homeless. Many education personnel find shelters very uncooperative in providing information about the children due to confidentiality concerns. While advocates are pleased that children are spared the stigma of homelessness, many education informants felt that children are short-changed when teachers do not know which children are homeless. The stress of homelessness can produce sudden disruptive behavior or call for a variety of other potential interventions that can be provided in the school setting if the school personnel knew the child's housing situation.

A final barrier is that transfer of records between schools is still a problem, especially when the family moves to a new State. However, since most school districts have now adopted presumptive eligibility for homeless children to enroll in school, this is now much less of a problem than a few years ago.

B. Pre-school programs, including Head Start, are not serving the majority of homeless preschool-age children.

Head Start offers the types of comprehensive services that homeless families need including a holistic approach to education, development, health, and parenting skills. Yet, only in Minneapolis are homeless children accessing Head Start, and in this city the effort (known as Project Secure) is funded through special, short-term, State dollars. According to Head Start providers, the barriers to homeless children's participation are three:

- In order to receive their Federal reimbursement, Head Start programs must maintain a minimum average daily attendance; by serving homeless children whose attendance may be sporadic, Head Start program funding is jeopardized. This is also true for followup services which Head Start is required to perform; yet followup is very difficult to do with homeless children.

- Nationwide, Head Start only serves 40 percent of the eligible population. In some cities, this figure is as low as 10 to 15 percent. Waiting lists are very long and homeless families are so transient that they have usually moved before their place comes up.

- Head Start serves 3 to 5 year olds, whereas many homeless families have younger children who are in need of developmental education services. For example, the targeted Head Start program in Minneapolis serves children 5 weeks to 5 years old.

Clearly, homeless families can benefit from being enrolled in a Head Start program that continues once they are permanently housed. Yet, the team saw no outreach efforts by mainstream Head Start agencies except in Minneapolis. There, Project Secure's advocates do outreach at the largest shelter as soon as the family enters the shelter. While the child is in Project Secure, the advocates work to secure a place for the child in mainstream Head Start programs near their intended permanent housing so that the child can receive continuous services. Advocates report that this system succeeds in placing approximately half of Project Secure's eligible participants in mainstream Head Start programs.

IV. Employment

A. Links to employment and employment and training programs are weak; adult members of homeless families rarely benefit from these programs.

1. Homeless adult family members are beset with many problems that translate into multiple barriers to gaining employment.

The typical homeless family is headed by a woman with young children. In many cases, she has not graduated from high school and has few basic educational skills. In addition, homeless mothers often have little or no work experience and generally do not know how to go about getting a job. They often lack self-esteem, feel disempowered, and have poor life management skills. Finally, the prospects of their getting affordable child care for their children before, during, and after school are slim. As a result, the probability of homeless mothers receiving gainful employment is poor.

2. Existing job training programs are funded with inflexible dollars that make it difficult to serve homeless families.

The study team found that existing education and job training programs for AFDC recipients or other low-income individuals rarely target homeless individuals or family members for their programs. If they are serving homeless individuals, homeless advocates are not aware of it.

According to homeless service providers, the reasons for this are easy to understand. Although programs such as JTPA and JOBS are geared to disadvantaged populations, these programs are not able to address the comprehensive needs of homeless adults. Homeless participants may need a driver's license, a new pair of shoes, diapers, money for the bus, and a place to shower and pick up mail or phone calls. Above all, the primary concern of homeless adult family members is housing. After housing is located and families leave shelter, they need assistance with "start-up" costs, such as clothing, furniture, and utilities. For homeless mothers, the greatest need is safe, adequate, reliable child care.

Existing job training programs do not have the flexible funding to provide these wide-ranging services. JTPA and JOBS programs are required to place a specified number of program participants in positions at certain wage levels; this gives these programs an incentive to "cream" clients and a disincentive to serve hard-to-serve clientele, such as the homeless. According to informants in Minneapolis, where a significant percentage of the homeless are from out-of-State, employment and training programs require proof of AFDC participation over a certain period of time. Homeless families often have difficulty providing this type of documentation on short notice and, therefore, are declared ineligible.

3. **A very small number of programs with flexible funding are providing comprehensive employment and training services to homeless families.**

In two cities, the study team found employment and training programs that were developed specifically for homeless individuals and family members. In Oakland, the Jobs Consortium pools the resources of three local organizations to provide comprehensive services to homeless individuals and adult family members at one site. Counseling, job development services, education and training, and linkages to shelter are offered. In addition, the program has a drug and alcohol counselor on staff. The program is funded through a grant from the Department of Labor.

In Minneapolis, the Hennepin County Homeless Family Training and Employment Assistance program used McKinney funds to create a pilot employment and training program for homeless families with children. The program gains access to families through the shelter system and then offers them a variety of services including permanent housing, case management services, and employment or training with the goal of long-term, gainful employment. The unique feature of this program is that services are provided at the same site as the State's JOBS employment and training program, STRIDE. As a result, homeless family participants have access to many of the same services as STRIDE participants such as child care, GED services, employment and training, and therapeutic services. All these services are provided in one place, rather than requiring participants to take the bus all over town to access services.

4. **Some transitional housing programs are providing employment and training services but residents often do not remain in programs long enough to become self-sufficient.**

The study team found that in the five cities visited, transitional housing programs and services-enriched housing are providing some education, skills development, and work opportunities. For example, in Baltimore, the Transitional Housing Program offers job training, academic preparation (GED), and family life skills training all in the same site where families are housed. THP tenants are required to create a workplan contract that is reviewed every six months to ensure that goals are being met. Other programs operate in a similar fashion. Among advocates there is some concern that because THP tenants often leave programs long before the 18 to 24 month program limit, they are not able to take advantage of employment and training services which often take 1 to 2 years to be effective.

The Family Development Center in Baltimore includes an employment and training center on-site at a high-rise public housing project. Services provided include GED and employment and training. More importantly, the program is linked to Maryland's JOBS welfare reform program, Project Independence, and has been approved as a training site for Project Independence participants.

5. **Successful programs serve the family in a holistic, family-centered fashion; provide services at one-site; and use key services to leverage participation when necessary.**

Based on the observations of the site visit team and the comments of staff of employment and training programs for homeless individuals and family members, transitional housing programs, and the family support/development programs, there appear to be a few key features to successfully providing employment and training services to homeless families. First, the programs address the permanent housing needs of homeless families. Second, services are holistic and take into consideration the multiple problems of homeless families, in particular homeless mothers' child care needs. Third, services are provided at one site. If mothers are required to travel by bus to a variety of different locations, the program becomes too burdensome. And finally, where necessary, key services such as child care are used as incentives to ensure that adults participate in the employment and training or other key program components.

V. Child Care

A. Lack of adequate child care once families leave the homeless service system is one of the most frequently cited obstacles to independent living for homeless families.

1. **There are varied child care options for sheltered mothers; however, needs are still not fully met and these options disappear once they leave the shelter.**

Other than affordable housing, no single obstacle to independent living was cited more frequently than child care. This is true both during the family's episode of homelessness and especially after they leave the shelter.

In all the cities visited, targeted child care services for homeless families were in operation or underway. These ranged from partial-day on-site child care, to full-day, on-site and off-site options. As with health care, while providers would prefer to use the mainstream system, it is already overburdened, unaffordable, and raises logistical obstacles such as transportation for families that are on the move all day.

In Atlanta and Baltimore, special child care centers for homeless children serve multiple shelters and THPs. Transportation problems are solved with van service and preferences are typically given to parents looking for employment. Child care needs of sheltered families are more fully met in Atlanta than in any of the other cities visited. There are two child care centers serving shelters in the metropolitan area plus several on-site child care centers. In the other cities, child care services varied. In Baltimore, a full-day child care center for children in shelters and THPs was just getting started. In Minneapolis, the Head Start program targeted to homeless children--

Project Secure--serves a child care function among its many functions, but only for children in the main family shelter.

Many of the special programs are approaching or at capacity. Several other ad hoc options have developed to meet the additional needs of homeless families for child care including in-shelter partial-day programs, collective babysitting and similar informal arrangements.

Stringent State child care regulations have posed an obstacle to developing on-site child care in most cities. Licensing regulations can make establishing child care centers prohibitively expensive for shelters; facility and zoning requirements may prohibit it outright. Atlanta was an exception; some shelter child care centers may be exempt from State licensing criteria.

Although the team found arrangements for full-day care, there are few drop-in or respite care options. These are important for mothers who have episodic needs for child care while hunting for work, health care, or entitlements.

For homeless families that do receive child care while in shelter, the lack of mainstream child care options hits them suddenly as soon as they become permanently housed. Most child care programs for sheltered families offer some assistance in searching for child care services and several programs offer transitional care to give the mother time to find more permanent arrangements. In Atlanta, a private foundation offers several weeks of free care and two additional weeks at half rate. However, site visit informants report that even when assistance is provided, many mothers do not end up finding affordable care. Unless they make informal care arrangements, most forgo employment and stay on AFDC so they can care for their children during the day. Even if they arrange for informal care, these arrangements are often unstable which can ultimately cause the family to return to AFDC.

2. Subsidized child care is in short supply and is one of the major obstacles to self-sufficiency.

While shelter providers are anxious to play a role in linking parents to mainstream child care, the fact is that most options are not affordable and subsidized care is virtually nonexistent in all the cities visited. All States subsidize child care through distribution of vouchers to eligible recipients or by allocating subsidized slots to specified child care centers; however, the demand far exceeds the supply. Waiting lists are as long as 8 months to a year in some areas. In some cities, it was estimated that only 33 percent of those who needed vouchers were receiving them.

One innovation of the Federal JOBS welfare reform program is the provision of subsidized child care for welfare participants who are involved in training or education; subsidized child care continues into the first year of employment. The Federal government pays for a portion--approximately half--of the cost of child care and treats it as an entitlement for all eligible participants. However, while the Federal government has not capped their contribution, in all the States visited, the State government had added additional restrictions on participation in their version of JOBS in order to limit the State contribution to child care.

The new ABC child care bill which will provide a combination of block grants and matching funds to States, may ease some of the shortages of affordable child care. However, the potential impact of this program is still unknown.

VI. Other Support Services

A. Emergency shelter is not the best time to provide long-range support services--clients are disoriented, transitory, and in a state of crisis.

Many shelters are providing mainly room and board; however, most feel the need to provide some level of additional support services such as training in life skills, parenting skills, and activities of daily living. Support service programs vary in intensity and quality, usually depending upon the duration of the program. In some cities, shelters with 90 day stays may offer intensive programs that resemble THPs. Most, however, provide ad hoc support groups run by volunteers and by residents. Some programs require clients to participate in support services to receive shelter; most offer services as an option.

Informants indicated that programs providing support services meet with variable success. The most successful are those aimed at the immediate need--how to find housing and keep it. In one city, a program provider indicated that their attempts at parent-child interaction groups were generally used as respite care by the mothers. Many informants believed that shelter is too stressful a time to work on long term personal issues with homeless families. The short duration of shelter stay is better used to help families become stabilized and linked to mainstream services; other support services may have more success as a followup service.

Some providers feel that even with the relatively short shelter stay, opportunities to provide child-related support services should be pursued. These would help meet the child care need among sheltered families and may be the only consistent part of a child's life during this period of turmoil.

B. Child protective services does not remove children from their families for homelessness alone. However, the parents' homelessness does make it difficult to reunite families that have been separated for other reasons.

1. For families in shelter who have children under CPS custody, reunification is very difficult to achieve.

Homelessness is not considered environmental neglect in any of the five cities, nor is distributing children to families or friends before becoming homeless considered abandonment. However, in virtually all of the cities visited, if children are removed from the home prior to homelessness, it is very difficult to reunite the family while the parent is in shelter. One exception to this was observed in Baltimore, where the largest and most comprehensive shelter program reported that they are sometimes able to reunite families because CPS views the program as providing a stable environment. Women, Inc., a program for substance users in Boston, also reported success in bringing families back together. Program staff have developed close working relationships with their area CPS workers and have made reunification one of the program goals.

While the good relations between homeless advocates and the CPS staff may be attributed to good advocacy and education by homeless workers, it is equally true that the CPS system is overwhelmed in all the cities visited. In several cities, advocates and shelter providers indicated that when there are concerns about abuse and neglect among shelter families, it is difficult to get CPS to respond because the system is already overburdened. Some program providers expressed concern about women whose children are removed from their custody while in shelter; reunification is even more elusive for this population. Once children are removed, these women are no longer eligible for family shelters and must turn to the less comprehensive singles shelter system. Often these provide night-shelter only, which leaves no suitable alternatives for the mother to be with her children in a stable environment on a regular basis--key requirements for reunification.

2. **Many mothers have relinquished their children to relatives and friends before entering the system.**

Although the CPS system does not remove children from the home because of the mother's homelessness, in most cities mothers are voluntarily dismantling their families before entering the shelter system. While survey data were not available in all cities visited, in several of the cities, from 20 percent to 50 percent of parents had at least one additional child who was not with them.

The motivations are several. First, the mothers do not want to subject the child to the stress of homelessness unless absolutely necessary. Second, mothers fear the CPS system and do not want their children taken into custody. Third, many shelters do not accept older male family members--usually the age limit is 12 years, although the team found one shelter where the limit was 8 years. Fourth, many shelters cannot accommodate families with more than two to three children. Finally, many older children want to avoid the stigma of living in a shelter.

VII. Links to Other Systems

A. Links to WIC and the major entitlement programs are in place for homeless families.

1. **Most homeless families with children meet the eligibility criteria for WIC and the major entitlement programs including AFDC, Medical Assistance, and food stamps.**

While there were concerns a few years ago about homeless families being excluded from entitlement programs, the team did not find that to be a problem in any of the cities visited. Concerted efforts to remove obstacles to eligibility, especially residency requirements or permanent address requirements, have been successful. In 1988, the Food and Nutrition Service clarified a regulation regarding WIC benefits for those in institutionalized feeding situations. This clarification opened up WIC benefits for homeless mothers.

Although most families are eligible, not all may be actually receiving benefits. The causes of the discrepancy are three:

- In-migrants must reapply in the new State, and reapplication and documentation may take several months. For that period of time, homeless families are dependent on the public system or the targeted system for food, shelter, and health care. This problem is especially severe in Minneapolis where about half of homeless families are in-migrants.

- Homeless families are transient and are sometimes lost to the AFDC system. If their eligibility lapses because of loss of contact, they must reapply.

- Many homeless women with children were in doubled-up situations before becoming homeless. They were not receiving benefits while doubled-up and are just applying for the first time.

Most informants indicated that the overwhelming number of families were screened and linked to entitlements by the time they left the emergency shelter system. If, as national data seem to indicate, they are not receiving benefits after they leave the system, it appears to be due to transiency or other factors that cause them to be terminated for administrative reasons.

2. **Regular screening for entitlements and WIC is conducted by most homeless family service providers.**

In all cities visited, families were screened for major entitlements and WIC at several points in the service system. In cities where the intake is centralized within the local government, the eligibility worker screens for benefits. Health Care for the Homeless and almost all of the shelters and THPs that were visited routinely screen for eligibility. Some programs have information and referral arrangements with the local social services staff.

Although entitlement screening was common, only a few programs were able to take applications for entitlements. HCH in Baltimore was attempting to out-station a Medicaid eligibility worker. In Atlanta, the Homeless Women and Children Program visits the shelter to offer resettlement assistance including taking applications for entitlements. In Oakland, several efforts are undertaken to ensure that homeless people have a steady source of income. While 25 percent indicate they have no source of income upon entering the shelter, only 10 percent have no source upon leaving the shelter because the staff makes an effort to link them to AFDC or SSI.

3. Although mothers are screened for WIC, WIC benefits must be modified to accommodate sheltered mothers.

WIC program eligibility was the least likely to be included in screening. Typically WIC screening was performed by a health program such as HCH or the on-site shelter clinics. In most cities the screening organization is able only to screen and refer; certification and voucher distribution are done at another site. In Atlanta, HCH staff concluded that only about half of their WIC referrals were actually proceeding through certification. As part of a special demonstration program, WIC personnel are staffing HCH mobile clinics, taking WIC applications and distributing vouchers at the shelter.

Traditional WIC benefits have limited utility for mothers in shelters because the food amounts are too large to use in a single day and mothers do not have access to refrigeration. The Atlanta demonstration project is addressing this second problem by modifying the WIC package to include nonperishable dairy products and by offering coupons for small amounts of food.

B. Demand exceeds supply for almost all types of substance abuse treatment to which low-income people have access.

While most advocates and providers agreed that substance use issues are less prevalent in the family homeless population than in the single adult homeless population, the number of families with substance use issues as a contributing factor in their homelessness or as an obstacle in their quest for independent living is high and increasing. Clients known to be substance users are not accepted by most shelters and substance use is typically included in shelter rules as one circumstance that results in immediate eviction. Almost all of the shelter providers indicated that, in spite of shelter rules, substance use remains a problem among the population they serve.

In all cities visited, the number of women in need of substance use treatment far exceeded the availability of treatment options. Most agree that outpatient care is not an effective alternative for homeless people with substance use issues because the user returns daily to a nonsupportive environment. Inpatient treatment is required and must be followed by residential care. Yet, capacity problems are particularly severe for inpatient programs and for long-term aftercare.

Even where options for substance use treatment for homeless people have been developed, as in Atlanta, women with children are rarely served. The reasons are two:

- There are few programs that can accommodate children while the mother is in treatment. Boston is the exception; the State has recently opened a network of 10 shelters that will allow the mother to stay with her children during the 9 month treatment program. While some cities try to establish links between shelters and outpatient programs so that the mother is reunited with the children at night, these programs face the same problems of nonsupportive living environment as other outpatient programs.

- Mothers will not seek treatment as individuals because they are afraid they will lose their children to the child protection system. Since children cannot be accommodated in shelter, mothers must either give the children to friends or surrender them to foster care. Since many homeless women lack an informal support structure, foster care is the more typical solution. Reuniting homeless families once the children have been removed is very difficult. In addition, there is the widespread belief among homeless mothers that they will lose AFDC benefits if their children are removed while they seek treatment. In most States this is not true; mothers may be separated from their children for short periods of time and still receive benefits.

A few innovative programs exist which serve the low-income population in general in the cities that were visited, and which can be adapted to meet the needs of homeless women with children. Where residential programs cannot accommodate children, one answer has been to create long-term child care programs that are not connected to the CPS system. In Atlanta, there are several experimental programs which will assume the care of the children for the 28-day treatment period.

Another innovative approach in Atlanta actually involves CPS directly. The Granny House, a CPS-sponsored demonstration program in a public housing project in Atlanta, is one example. Caregivers in the project are trained to care for children of women in treatment; the women understand from the start that the children will be returned upon completion of the program. Comparable programs for women in followup residential care were not identified.

Women, Inc., a residential treatment program for women located in Boston, includes CPS in a less formal way. Women in the treatment program are not allowed to have their children in residence during the first three months of the intensive year-long program; however, reunification is a goal for the second phase of the program. Program staff assist women in finding placements for their children and the first choice is always family or friends. However, program staff have developed close working relationships with the area CPS case workers, and when no other options are available, children are placed into foster care with the explicit understanding that reunification is a goal within the next 3 to 4 months.

C. Battered women are often counted as part of the homeless family caseload, but the domestic violence system and homeless service system are separate and the links between the two systems are not strong or visible.

The homeless family shelters and battered women's shelters are separate service systems in all of the cities visited. The two service systems are typically funded through different mechanisms, have different administrative structures, and conduct intake and referral through autonomous networks. While some cities have informal linkages between the two systems, no formal linkages were identified.

Yet, all informants reported that for a significant percentage of homeless families, domestic violence is a contributing factor. In Minneapolis, domestic violence was found to be the main cause of homelessness for 25 percent of families and a contributing factor for 50 percent. It is likely that many of the same factors that influence homelessness also help to create the stressful, unhealthy environment that leads to domestic violence.

Many of the advocates and providers interviewed indicated that the homeless shelter system is increasingly experiencing the overflow of an overburdened domestic violence system. None of the shelters visited are able to keep their location confidential or offer protection to women fleeing abusive relationships, which are typical service components of battered women's shelters.

Chapter VII

Policy and Program Issues and Barriers

Chapter VII. Policy and Program Issues and Barriers

The five cities visited were selected because each was known to have fairly comprehensive services for homeless families and because each was believed to have taken a somewhat unique approach to service delivery in at least one policy area relevant to the study. While the team endeavored to select cities that were diverse geographically and programmatically, by no means can the results of the site visits be used to make generalizations about homeless services in other locations. Nevertheless, the patterns and themes evident in the five cities highlight issues and barriers that are likely to be experienced by all service systems addressing the needs of homeless families.

This chapter provides a discussion of key issues identified across the five cities that present barriers to serving homeless families with children. This chapter also considers the implications of these issues for programs serving homeless families and for Federal policy in this area.

I. Unless incomes go up or rents go down, poor families will be at-risk of repeated episodes of homelessness.

Undoubtedly, many families are homeless because of personal problems such as domestic violence, substance use, or mental illness. However, even these families are poor first and troubled second. While addressing personal issues will remove some barriers to self-sufficiency, once "cured," these families will still face inadequate financial resources for housing.

In the long run, the solution to family homelessness lies in public and private measures which will improve the situation of all low-income families. As all informants stressed, the homeless are not unique. As one said, "Poverty is a continuum; homeless families are just so poor that they fell off." Measures which act to raise the incomes of the poorest of poor families or increase the availability of subsidized housing, while very expensive, attack family homelessness at its roots. Initially, AFDC benefit increases are necessary until families can achieve self-sufficiency. States and the Federal government need to address the issue of benefit adequacy, especially for those dependent on public assistance for longer periods of time.

But AFDC benefits and housing subsidies are palliatives. Building self-sufficiency is the longer term solution. Families will need education, employment skills, and child care to get and keep jobs paying a living wage. With the initiation of the Federal JOBS welfare reform programs, AFDC can be a link to longer term self-sufficiency. However, eligibility requires sustained AFDC program participation. Yet, national research indicates that from one-half to two-thirds of homeless families do not get AFDC. If the five cities visited are typical, homeless families are screened and linked to AFDC during their shelter stay; something happens once they leave the emergency shelter system that causes them to lose benefits.

Although homeless families are just the most extreme manifestation of the more general problem of family poverty, it is understandable that those who are currently homeless attract the attention of policymakers and the general public; there are measures that can be taken to address the needs of that portion of the low-income family population that is currently homeless. Actions which will help raise incomes, lower barriers to higher paying jobs, or lower rents include the following:

A. Emphasize education and skills training which will improve the access of families to higher paying jobs.

Homeless women with children are typically undereducated, underskilled, and often lack even basic employment skills. When they can secure jobs, advocates in the five cities visited indicated that these were almost always minimum wage jobs that left them little better off than welfare benefits and worse off when the cost of private child care and transportation were included.

Funds would be better spent on literacy, GED, and job skills training which will raise the general level of employability of these mothers. While this approach means that mothers will stay on welfare longer, the long-run prospects for self-sufficiency are increased.

B. Use the homeless service system as a case-finding opportunity for targeted employment and training programs.

Traditional JTPA programs are not currently equipped to handle participants with the low level of employment skills typical of homeless women, although recent efforts to modify program incentives may improve services.

Similarly, in all cities visited, homeless women were rarely participating in the JOBS welfare reform program. Sometimes, this was attributed to State targeting criteria, other times to the mother's need to focus on the immediate need for food and shelter.

While modifications to these mainstream programs indeed increase access by homeless women with children, most informants feel that whenever homeless women are competing with others, homeless women lose out.

The site visits identified a few effective targeted employment programs. Based on the experience of these programs, targeted employment efforts should incorporate the following four key features:

- Address the permanent housing needs of families
- Provide services at a single site
- Provide holistic services that address the multiple problems of families, especially child care needs
- Use key services such as child care as incentives for participation in the full program.

C. Extend subsidized child care for homeless women into their period of permanent housing.

No barrier to self-sufficiency is clearer than child care costs. The cost of private child care exceed what can be earned on low-wage jobs and evidence indicates that homeless mothers are least likely to have the informal support systems that other poor women employ to meet their child care needs. Although limited transitional child care exists, there is typically no child care available once the family is in permanent housing.

Recently approved child care legislation will help expand the supply somewhat, but homeless women will still be competing with many low-income women who need these services.

Another way to expand the range of child care alternatives is to encourage the development of family day care and formal, informal, or collective babysitting arrangements. At least two of the States visited reimbursed for formal babysitting arrangements; these arrangements would be used more often if reimbursements were higher. In Atlanta, one component of the Robert Wood Johnson Homeless Families Program grant will train formerly homeless mothers and low-income mothers as family day care providers and encourage other homeless and low-income mothers to use this child care option.

D. Encourage Federal preferences for homeless families in making assignments to public and subsidized housing.

Homelessness is only one category within the sub-standard housing Federal preference which accords a priority for public housing and Section 8 programs. As one of several preferential groups, homeless families compete for housing. However, in cities where homeless families are accorded priority, the system works well in terms of placing families in public housing. While most informants note that many public housing projects are not an ideal environment for vulnerable families, in combination with AFDC and targeted support services, public housing can start the family on the road to self-sufficiency.

E. Encourage flexibility in use of funds for move-in assistance such as first and last months' rent, security deposits, or rent arrearages.

Housing is a patchwork of public and private sources in most cities and demand for public and subsidized housing far exceeds supply. A knowledgeable case manager can help families explore options for public and private affordable housing; however, relocation and resettlement assistance is broader than finding housing and should include linking the family to entitlements, income supports, and support services.

Where AFDC-EA programs exist, the funding is already in place to provide many resettlement services such as moving costs, first month's rent and security deposits. State funds can and do support similar functions where EA does not exist.

II. In the long run, the homeless services system is only as effective as the mainstream services to which homeless families can be linked.

No one would deny that a homeless family is in crisis and has an immediate need for food and shelter. However, if homelessness is an acute rather than chronic condition for individual families, as it seems to be in the five cities visited, then developing a comprehensive and coordinated system of homeless services is counter-productive if families will be returning in a few months or less to an underfunded, overwhelmed mainstream system. The supports that are established during their episode of homelessness will quickly deteriorate once the family is permanently housed. Yet, the mainstream system is threadbare in many of the cities visited. Consequently, besides the need for income supports and subsidized housing which were raised earlier, continued links to the following mainstream programs are needed:

- *Child care*: In some cities visited, demand so exceeds supply that only one-third of those eligible are successfully obtaining subsidized care.
- *Head Start*: Waiting lists of several years are common; yet, no program more closely approximates the comprehensive package of services that homeless families need.
- *Developmental services*: Opportunities for screening abound, but the availability of developmental services is limited in most cities visited.
- *Prenatal care*: As with most health services, referral by targeted health care programs for the homeless works well, but a variety of system barriers in the mainstream service system strains the initiative of clients to seek care.
- *Substance abuse treatment*: Demand, especially for inpatient services, vastly exceeds supply in all the cities visited.

In the opinion of most advocates, improvements to the mainstream service system will do more to alleviate homelessness than targeting additional funds at the homeless service system. A strong mainstream service system will stabilize those recently rehoused so that they can maintain independent living and will prevent those tenuously housed from falling into homelessness.

Unfortunately, large-scale improvements to the mainstream system are beyond the financial capabilities of most States and cities visited. However, there are modifications that can be made to the mainstream system, inadequate as it is, which will make it more accessible to homeless families with children. These are discussed in the next set of issues and barriers.

III. Lack of attention to the special needs of families while they are homeless creates barriers to access to mainstream services.

While homeless families closely resemble their tenuously housed low-income counterparts, being homeless presents practical problems that must be taken into account to effectively serve these families. Mainstream service providers may recognize the importance of providing preventive and acute care services to homeless families, but families are often overwhelmed with immediate crisis needs. In addition, homeless families are difficult to serve because (1) they move from place to place, (2) receive services from multiple providers, (3) rarely have access to transportation, (4) have child care needs, (5) lack support systems, (6) may not have the motivation to seek services, and (6) face bureaucratic obstacles such as long waiting lines, paperwork, and scheduling problems.

Several key approaches improve the accessibility and availability of services for homeless families. The first is outreach to access homeless families in places where they are most likely to congregate, such as shelters. The second is to coordinate services so that services are client-centered, comprehensive, and pose as few barriers for the family as possible. The third is to increase flexibility in program eligibility. Some programs may require detailed documentation of AFDC participation to ensure that participants are low-income; others require a child to meet rigid eligibility criteria. Finally, many existing mainstream programs specify that funds must go toward specific program-related activities only. Homeless families are served better by less restrictive funds such as McKinney Act funds that can be used to pay for what a homeless person needs to be self-sufficient, whether that is housing assistance, bus tokens, or clothing assistance.

Site visit findings suggest the following adaptations:

A. Encourage flexibility in WIC programs through innovations that address the realities of shelter life for homeless mothers.

A WIC demonstration project currently being conducted by the Atlanta Community Health Program for the Homeless has two key features of particular interest to this study. First, eligibility, certification, and voucher distribution are centralized to overcome the logistical obstacles that were causing only half the screened mothers to seek certification. Second, the project modifies the WIC food package to recognize the realities of shelter life including coupons for small amounts of food and nonperishable dairy products for those without access to refrigeration.

B. Allow for modifications in Head Start so programs can accommodate homeless children and families.

The goals of Head Start epitomize the intensive support services approach that is desired for homeless families. Yet most homeless families are not able to access the program because they do not have transportation, program hours do not meet the needs of homeless mothers, and because the age served excludes many homeless preschool-age children. From the Head Start program perspective, homeless children are difficult to serve because their transiency makes meeting reimbursement requirements for daily attendance and followup difficult. Altering the hours, age limits, performing outreach to shelters, and offering requirement waivers to programs would enable many homeless preschool age children and their parents to participate in Head Start. If Project Secure in Minneapolis is representative, these modifications may be needed for just the short period of time that the child is homeless. In Minneapolis, once the child is permanently housed, he or she is linked to mainstream Head Start services.

C. Allow for flexibility in use of funds and modifications in the performance incentives for employment and training programs that will encourage them to serve homeless adults with lower skill levels and multiple problems.

Funding for traditional employment programs needs to be made more flexible in order to meet the multi-faceted needs of homeless women with children. Like the Health Care for the Homeless projects, employment programs must be permitted to devote resources to comprehensive case management and to finding support services for participants. In addition, current incentives to place clients only in jobs which exceed a certain wage level, while well-intentioned, should be modified to place workers in entry-level jobs so that more hard-to-serve populations such as homeless women with children will gain access to these programs.

D. Encourage States to provide transportation for educational access for homeless students.

One key to minimizing the disruption and stress of homelessness for school-age children is continuity of education. The key component to make this work is providing transportation so that the child can remain in the school of origin. Although the educational provisions of the McKinney Act mandate that access be provided to whatever school is in the child's best interest, transportation assistance is the decision of the local school district; yet without transportation there is rarely access to the home school.

IV. Lack of followup means no one knows if the service system is effective or not.

This is the most far-reaching gap the team found. The fact is that in all five cities visited, no one knows what becomes of homeless families. In some of the cities, families are lost once they leave any program; in the cities with centralized intake, the family can be tracked so long as they are in the homeless service system, but then they are lost. Because there are multiple shelter options available in most cities and because shelter resident data are not centrally collected or analyzed in most cities, intake data is not a productive way to calculate recidivism. Consequently, theories about the fate of homeless families abound--that they are going to other shelters, that they end up in permanent housing, that they return to unsavory relationships--but only anecdotes could be offered as evidence in the five cities visited.

Lack of followup is important for several reasons:

A. Knowing the extent of recidivism is essential to defining the role of the service system for homeless families.

If homeless families are chronically or repeatedly homeless, then the service system should be playing a very different role than if families are experiencing brief, sporadic periods of homelessness. Even if families are moving from program to program, if they are in the system for long periods of time, then the opportunity to provide more than stabilization services exists. Through strong case management, families can be linked to programs which can begin to address personal and life issues, employment skills, and health care concerns while the family is homeless.

On the other hand, if most families are exposed to homelessness for only brief periods of time, then services provided during their homelessness should concentrate on stabilization and outreach for mainstream programs so that the family is linked to long-term support services before returning--sometimes in a few weeks--to the housed low-income family population.

Knowing the facts about the fate of homeless families will help the system focus its meager resources.

B. Followup will reduce the need for more steps in the housing continuum.

In all cities visited, providers--even those providing transitional housing--questioned the need for additional steps in the housing continuum. While recognizing that a certain portion of the homeless family population needs special services in a congregate setting, most advocate for providing these services in permanent housing. Some mainstream services are already in place in the communities where the families will be permanently housed; adequate followup will ensure that the links made during the family's sheltered period are established once the family moves to permanent housing.

None of this solves the crucial obstacle in followup--that families do not want to be followed. However, although families are anxious to shake the stigma of having been homeless, the experience of the cities visited indicates that they will stay in contact with the system if a bond has been established, or, more importantly, if needed services are attached to the followup.

Some ways to enhance followup might include the following:

- Incorporate followup as an appropriate use of funds as it already is for Health Care for the Homeless and Head Start.
- If possible, vest a single entity with responsibility for followup. Ideally this entity should have access to an updated address database, such as the AFDC database, which is likely to include families after their period of homelessness has ended.
- Where a single entity cannot assume responsibility for followup, encourage programs to track participants at periodic intervals for at least a year using a variety of techniques such as mail-back cards, telephone inquiries, or designated followup staff.
- Develop incentives for families to stay in contact with the system after they leave services; one incentive might be continuation of services such as child care beyond the period of program participation.

V. Services are fragmented and duplicative.

Human services are organized categorically; unfortunately, the problems of homeless families cross the traditional categories. Providing services to a homeless family may involve packaging efforts of many different agencies and public and private entities which is not a simple task. This problem is exacerbated by the nature of the Federal response which has tended to be through a series of targeted programs under the general rubric of the McKinney Act and by the mixture of funding streams at the State and local level.

Coordinated services planning--sometimes known as case management--while not a panacea, is clearly a need for homeless families. Currently it is applied inconsistently depending upon the program in which the family is involved, the duration of the services, and the funding. A stable funding source which locates case management at a central service such as housing or as part of the intake function in public systems would go a long way to expanding the coverage of the system. The advantages of case management are several:

- It would eliminate duplication of services by centralizing records and efforts.
- It would vest responsibility for linkage to the mainstream system in one place, either a stand alone function or integrated into a service received by most homeless families such as shelter or education. Currently, responsibility is so diffused that some things never get done.
- It would provide a starting point for followup in permanent housing. This is the transitional piece that is missing. Even where some case management is taking place, it ends at termination of an individual program. Centralized case management would provide continuity across programs and provide the opportunity to follow the family into the permanent housing.

Some ways to enhance coordinated services planning might include the following:

- Incorporate case management as an appropriate use of program funds.
- If possible, centralize case management in one entity such as a multi-services center. This minimizes the number of case plans being developed for a single homeless family and ensures that families who do not participate in services such as shelter or health care, where case management is currently most likely to take place, have access to coordinated services planning.
- Develop strong ties between the case management entity, the public housing system, and the entitlement system. Housing and entitlements are the cornerstones of short-term self-sufficiency for homeless families; case planning should be able to offer these resources.
- Encourage maximum client participation in developing the case plan.

VI. Inadequate links between services and housing means support services end when they are needed most to sustain independent living.

A. Encourage services-enriched housing models.

Clearly, services-enriched housing is a strongly held preference among advocates. It avoids creating additional steps in a continuum to earn permanent housing. It recognizes that for some families homelessness is solely a housing problem, while for others the solution to their homelessness involves both housing and support services in durations and combinations that will vary for each family.

Elim Transitional Housing, Inc. is successfully employing services-enriched concepts with homeless families in Minneapolis. One other successful model of services-enriched housing, the Family Development Center and Family Support Centers in Baltimore, targets families in public housing and low-income neighborhoods, not homeless families. But the model is adaptable with few modifications.

The Family Support Center provisions authorized (but not appropriated) in the current McKinney legislation adopt a similar model and are an important first step. This new demonstration program is designed to provide easily accessible and comprehensive support services to low-income families in order to prevent homelessness and improve the living conditions in low-income neighborhoods. Emphasis is on those at risk of homelessness, including very low-income families who were previously homeless and who are currently residing in subsidized housing. Services, provided through intensive case management, may include health and nutrition, employment training, child care, and domestic violence counseling among others. Funds may also be used for housing counseling and foreclosure prevention. The program also will fund several "gateway" projects in which local education agencies will provide on-site education, training and support services, including child care, to economically disadvantaged residents of public housing to foster self-sufficiency.

B. For special needs such as substance use or mental illness, encourage options to meet the needs of children of women in treatment.

In the opinion of experts, inpatient, long-term substance abuse treatment is most likely to produce a successful long-term outcome, especially for poor women who are usually returning to unsupportive environments. Funding needs to be provided to accommodate these women and their children in treatment settings.

The Shelter Plus Care provisions of the new McKinney legislation address some of these issues. Shelter Plus Care is intended to provide rental housing assistance in connection with support services funded from other sources. At least half of the funds are to be reserved for homeless individuals who are seriously mentally ill, have chronic alcohol or drug use problems, or both. While Shelter Plus Care addresses the housing portion, the grant applicant must match the rental housing assistance with an equal amount of funding from other sources for support services.

Consequently, programs will be as good as the services the mainstream system has to offer. Hopefully, Shelter Plus Care will serve as an incentive to integrate housing and support services; if not, unless Shelter Plus Care rental housing is clustered, participants may face the same problem of unsupportive living environment that is currently faced by residents of public housing who are receiving outpatient substance use treatment. Nevertheless, it helps address the need for residential environments where women can live with their children while participating in treatment programs.

VII. Summary

Family homelessness persists as a problem. The site visits identified themes and patterns that were common to five very different cities which have taken diverse approaches to addressing the needs of homeless families with children.

In each of these cities, the project team found promising and innovative methods for addressing immediate needs. The site visit team also found advocates and providers who were intent on emphasizing that immediate needs were symptoms of a more deeply-rooted structural problem. In their view, creating good homeless services, while well-intentioned, will not attack family homelessness at its roots.

The site visits identified a variety of obstacles that can be overcome to make the existing homeless service system better, and, more importantly, to improve the mainstream system to which homeless families eventually need to be linked. These can be the starting point for a discussion of a broader attack on homelessness that addresses housing, incomes, and the link between housing and support services for at-risk low-income families.

APPENDIX A

DISCUSSION GUIDES

NATIONAL EXPERT PHONE DISCUSSION GUIDE

DISCUSSION GUIDE
EXPERT/NATIONAL CONTACT DISCUSSIONS

1. Describe study

   - ASPE study. Key interest is in identifying special needs, programmatic issues, and unique approaches to serving family homeless. **Not** interested except in cursory fashion in ascertaining prevalence or documenting size.
   - looking at state/local government and private sector responses to the problem and **unique or innovative approaches**
   - looking at **service needs and linkages**

2. Estimates of the extent of family homeless vary, what is your general sense of the prevalence of family homelessness in the nation?

   - trends over time
   - future prevalence

3. What do you consider the primary causes of family homelessness?

   - trends over time
   - future

4. What are the primary subgroups within the family homeless population (migrants/immigrants, drug users, economic casualties, domestic violence, others)?

5. What are the predominant types of family composition (intact, female-headed, few/many children).

   - trends over time
   - future

   What service system challenges does family composition present (refusing to accept older male children, intact families, fear of losing children to foster system)?

6. What are the specialized service needs of the family homeless?

   - by subgroup
   - as compared to homeless in general

7. What are the service/program linkages that need to be in place to meet these needs? (housing, schools, day care, employment, social services)

8. What are the major elements of an effective service delivery system? (how would the ideal service delivery system be configured)?

9. What are the major obstacles that programs face?

10. What are the knowledge gaps that need to be filled to help providers and agency officials in their efforts?

11. Do you know of any innovative programs or approaches, or those dealing with unique homeless populations that we should explore?

    - racial, ethnic, rural
    - transitional housing alternatives
    - unique approach to providing support services of making service linkages
    - HUD section 8 demonstration projects
    - contact names and phone numbers

ADMINISTRATOR AND CITY CONTACT PHONE DISCUSSION GUIDE

DISCUSSION GUIDE
ADMINISTRATOR/CITY DISCUSSIONS

Introduction of the project should include the following points:

- We're conducting the study of family homelessness for ASPE, part of HHS.
- Looking at the extent of the problem, the unique needs of homeless families as compared with the needs of homeless population generally
- Not as interested in prevalence or documenting size of population as in programmatic concerns and needs
- Looking at how programs and governments are responding to the problem, and any particularly unique or innovative ways
- Not evaluating the approach of any city or program. Looking at your city as one of many so we can get a national picture of the diversity in approaches.
- Calling you to get an overview of what's going on in (city),not just the government response but in the service system generally.

1. Could we have a little background on the structure/system for homelessness in (city)

   [Probes: Exact numbers not necessary

   - # of emergency shelters in city & capacity
   - # transitional facilities & capacity
   - # dedicated to families]

2. In (city) are there any definitional issues around family homelessness, especially ones that affect eligibility for services or where you would send people for services?

   [Note: There is a FEMA definition, and a McKinney definition, and some states have their own definitions. Eligibility under these different definitions may influence what services you can receive. Also, if eligible for AFDC, then presents another list of options.]

3. In your city, would you say the size of the homeless family population growing, staying stable, or declining?

4. Could you tell us a little about the make-up of your family homeless population. For example, what is the racial mix? Do you see distinct subgroups or segments within your family homeless population.
   [Potential probes:

   - racial composition
   - proximate "cause" (e.g., migrants/immigrants, drug users, spouses of drug users, economic casualties, domestic violence..)]

5. Are there issues related to family composition? For example, what is (are) the predominant family types among the family homeless population (i.e., intact, female-headed, male-headed...). Is the service system able to accommodate intact families? How does the service system handle families with older male children [Note to interviewer: "older" may mean an age as low as eight years old in some cities.]

6. When you compare with other cities, is there anything unique or different about your own homeless family population (i.e., a unique racial composition, a unique cause of homelessness, migrants/immigrants)?

7. Special service needs of homeless families (as compared with homeless population in general)
[Probes:

- Thinking here specifically of adjunct social/support services.
- Services directed at children in homeless families
- For specific subgroups (e.g., immigrants, drug users, economic casualties, domestic violence)

8. How do you handle the service linkages to meet these needs?
[Probes: Some key services where linkages must be made:

- Schools,
- Day care,
- Employment
- Social services/income maintenance

a. Who makes linkages (e.g., case manager--shelter based, city employee)

b. Where are services provided (e.g., on-site, different locations in city)

c. Gaps in service. Key links that are missing or are inadequate.

9. Please describe some of the efforts/approaches to serve homeless families in (city)
[Probes: Try to get an idea of:

- Services and organization
- Funding: role of McKinney funding? HUD Section 8 demo grant?
- Key players (contact names & phone numbers)
- Any special city or state initiatives
- Any special private initiatives
- Future initiatives at city or state levels]

10. Thinking of other cities and programs you might know about, are there any unique or promising approaches of which you are aware, either government or private efforts?
[Get contacts and phone numbers if possible]

11. If I wanted to get a complete picture of family homeless situation in (City), who else would I need to talk to?
[Probe for:

- State/county/city government as well as providers and advocates. Some contacts may already have been mentioned in talking about approaches above.
- Get contacts and phone numbers if possible]

12. Get their address and correct name spelling [so we can send them a thank-you letter and, particularly if they have asked for a copy of the findings.]

SITE VISIT DISCUSSION GUIDE

SITE VISIT DISCUSSION GUIDE

The site visit discussion guide is divided into sections. Clearly, not all questions will be asked of all respondents. Rather, the guide attempts to present the entire range of information we would like to obtain in the course of the case study.

This information can be grouped into categories. By the end of the case study, we will need to have examined the following issues in each of our case study cities:

I. Contextual issues
II. Comprehensiveness of the array of services
III. Detailed description of individual programs, particularly services for children
IV. Coordination and links among the components of the system

The major discussion topics under each heading are presented below:

I. Contextual Issues

Questions in this section would be asked primarily of those with a system-wide perspective such as public officials, city administrators, and coalition/task force representatives. The intent of these questions is to get a **rough overview** of the context/frame of reference in which the **service system** and individual programs for homeless families operate. We anticipate that much of the background information--such as, demographics, taxonomy, and incidence/prevalence--will be obtained through review of documents during or after the site visit.

Portions of the framework for this section build on the issues contained in the expert and city administrator phone discussion guide; however, the site visit will allow us to explore even these issues in more depth and with more people.

A. Characteristics of Homeless Families

1. Employment status(unemployed, employed part-time, employed full-time)
2. Racial/ethnic composition
3. Family composition (intact, male-headed, female-headed; number and age of children)
4. Special groups (migrants, rural homeless etc.)

B. Factors Related to Family Homelessness

1. Economic/Structural

   - Housing market conditions
   - Availability of and trend in low-income housing

- Extent of families in doubled or tripled-up situations
- Comparison of AFDC levels and HUD Fair Market Rents
- Employment market
- Wage structure for low-skilled personnel

2. Individual

- Drug problems
- Domestic violence
- Teen pregnancy
- High school drop-out rates

C. Political/Social Climate

1. Attitude of the general public toward homelessness and homeless families. General public's support as measured by philanthropy, fund-raising, media attention, public initiatives.
2. Local government role and involvement, in general, in provision of services to homeless families.
3. Relations between family homeless advocate/provider community and:

    - Elected officials
    - Local government officials/bureaucracy
    - State/federal agencies
    - Business community
    - Philanthropic community

4. Key actors involved in getting support and involvement for homeless families with children
5. Coordination/fragmentation of political jurisdictions involved in providing services for homeless families (city, county, state, school district). Impact on funding, eligibility, and service provision.
6. General local/state climate regarding funding and provision of social services
7. Local/state legislation or initiatives affecting homeless families

D. System-wide Coordination

1. Existence of coalitions, networking groups, consumer groups of parents
2. Formal or informal service coordination, either government or non-profit
3. Maximization of funding streams. Cooperation/joint ventures on grantsmanship
4. Extent of public/private partnerships. Communication and coordination between city and private/voluntary sector

E. System-wide Barriers/Issues

1. Obstacles to providing comprehensive, coordinated services
2. Factors perpetuating family homelessness
3. Services most needed. Major service gaps.
4. Major problems programs are facing in serving homeless children
5. Barriers to program development
6. Problem(s) with duplication of services
7. Effectiveness of case management efforts.
8. Staffing issues
9. Training and technical assistance
10. Data collection, monitoring and evaluation activities

II. Comprehensiveness of Services

Information from this section will be used as a checklist to identify service availability and service gaps for homeless families, particularly in key services for children and for mothers of younger children. Again, the sources of this information would tend to be those with a system-wide perspective, although the components of the system would be fleshed out in conversations with providers, as well.

A. Housing Continuum for Homeless Families

1. Emergency housing
2. Transitional housing
3. Services-enriched housing
4. Permanent housing
5. Housing support services

   - relocation services
   - benefits counseling
   - landlord mediation

B. Services for Infants and Preschool-age Children

1. Health care (pediatric care, EPSDT, WIC)
2. Education (preschool, Head Start, etc.)
3. Developmental interventions
4. Socio-emotional support
5. Recreation
6. Child care
7. Child protective services
8. Foster care

C. Services for School-age Children and Teenagers

1. Health care
2. Mainstream education
3. Supplemental education/deficit reduction

    - in-school remediation
    - after-school supplemental education
    - ongoing educational support
    - social supports

4. Special programs for gifted or handicapped children
5. Socio-emotional support
6. Recreation
7. After-school child care
8. Child protective services
9. Foster care

D. Services for Mothers/Parents

1. Health care
2. Employment counseling and assistance
3. Job training/education
4. Life skills training
5. Parenting (including health skills)
6. Psychosocial counseling
7. Drug and alcohol treatment
8. Child care
9. Social supports/respite care
10. Follow-up/aftercare

E. Services Addressing Needs of Families

1. Cross-agency case management
2. One-stop service centers
3. Family support centers/services enriched housing
4. Advocacy
5. Legal representation

III. Program Description

This section is the core of the site visit. Questions in this section will be asked predominantly of contacts in specific programs and are intended to describe what is going on in a program and the linkages among programs.

Questions in this section fall into two categories: general investigation points that pertain to all programs, and issues specific to a certain program or category of program (i.e. education).

A. General Investigation Points

The following issues are likely to be addressed in our discussions with program personnel regardless of the type of program.

1. Organizational issues
    - History/mission/changes
    - Facilities and locations
    - Number of clients
    - Capacity
    - Waiting lists
    - Characteristics of clients
    - Recent changes in characteristics
    - Who is excluded
2. Points of entry
    - Information and referral
    - Intake
    - Outreach and identification
    - Method of accessing services: self-referral, case worker
3. Service delivery
    - On-site/off-site
    - Advantages/disadvantages of on-site/off-site
    - Services dedicated to homeless or shared with other clients
    - Advantages/disadvantages of dedicating or sharing
4. Accessibility of service issues
    - Language barriers
    - Cultural barriers
    - Transportation
    - Hours
5. Duration of service
    - Average length of stay in program
    - How/when are services terminated
    - Recidivism

    - When does person stop being a client
    - Follow-up/follow-along
    - Client's role
    - Incentives/sanctions
    - Stigma avoidance

6. Case planning

    - Who does it
    - Program's role in it
    - Client role in service decisions
    - Assessment and tracking
    - Frequency/method of reviewing case plan
    - How is duplication minimized
    - Recordkeeping
    - Continuity of care
    - Follow-up/aftercare

7. Relationship with other programs

    - Main/key linkages
        - formal
        - informal
    - Relationship to levels of government
        - funding
        - regulatory
        - referral

8. Needs of special populations

    - Substance use
    - Domestic violence
    - Migrants
    - Rural
    - Refugees

9. Effectiveness

    - How is effectiveness defined
    - How is effectiveness measured
    - Client outcome data

10. Financial

    - Budget
    - Funding and reimbursement sources
    - Funding and reimbursement gaps
    - Client payment mechanisms

- Screening for eligibility for government programs
- Cost breakdown by major category

9. Staffing issues

- Sources of staff
    - volunteers
    - professional staff
- Training
- Caseload
- Staff burnout/turnover

10. Barriers to program development

- Regulatory/government barriers
- Client-related barriers
- Funding barriers
- Organizational barriers

B. Program Specific Investigation Points

Besides general investigation points, each component of the service system is likely to have peculiar nuances or challenges in delivering services to homeless families with children. The following list presents some of these program-specific questions which will be asked when appropriate.

1. Housing/Services Link

What, if any, impact does family configuration have on the range of types of housing available:

- mothers with younger children
- intact families
- fathers with children
- families with teenage children
- extended families with children

How are the links to support services accomplished?

- location: on-site or off-site
- access: dedicated programs, priority, or mainstream
- coordination of housing and welfare funding
- coordination of housing and welfare eligibility
- impact of separate jurisdictions for housing and welfare services
- impact of separate eligibility requirements for housing and welfare services

As the family moves through the continuum of services, how do the links to comprehensive social services change?

- location
- access
- ability to provide services once family moves into permanent housing

What percentage/number of families are moved into transitional housing?

What selection/screening criteria are used to select families for transitional housing? What happens to families who are not selected?

What is the general philosophy/approach to transitional housing (congregate, scattered site)

What is the relationship between homeless housing system and HUD Section 8? Public Housing Authority?

What percentage/number of families are moved into permanent housing?

What selection/screening criteria are used to select families for permanent housing? What happens to families that are not selected?

2. Education of school-age children

Are children in your program attending school? What percentage? How often do children change schools per year?

In general, is the education system in your community responding to the needs of homeless children?

Are homeless children mainstreamed or are they attending special programs (either on-site or elsewhere)?

Who makes the decision as to what school children attend? Are the parents' desires taken into consideration?

Do families have a problem with school residency requirements?

Do schools offer assumptive eligibility, i.e., is there a problem with schools requiring immunization records that families do not have? Are schools transferring records as children go to different schools?

What type of transportation is provided to help children get to school? Who pays for it?

Is any after-school tutoring provided at the shelter (program)? Is there any training for teachers about the particular needs of homeless children?

Are homeless children able to access special education programs (gifted, ESOL, special education)?

How are evaluations performed? Are needs of homeless children addressed?

3. Education of preschool age children

Are homeless children involved in preschool or early intervention programs such as Head Start? What prevents greater rates of participation?

When children leave the homeless service system, are they able to retain Head Start eligibility and enrollment?

4. Substance use

How are links to inpatient and outpatient care made? Do homeless clients get priority?

When homeless mothers are in substance use outpatient treatment, is the length of stay in the shelter adjusted to reflect the duration of the s/a treatment program?

What is the perspective of the foster care system on homeless mothers in substance use treatment?

5. Case planning

Who has primary responsibility for case planning? What is role of government?

If voluntary sector is responsible for case planning, how are multiple case plans avoided?

What is encompassed in case planning?

What is client's role in case planning?

How active is case worker with the client? How frequently is contact made?

What sanctions/incentives are available for fulfilling goals in the plan?

Does case worker have authority/clout to access services recommended in the case plan?

6. Child care

What is the relationship between the private day care system and the system for homeless families?

Are day care regulations a barrier to starting day care centers for homeless children?

What methods of providing day care are being employed? Collective babysitting? Dedicated day care centers? Vouchers?

Is day care access restricted to those participating in employment or training?

7. Health care

What methods are used to provide primary care? Vans? On-site personnel? Dedicated clinics? Public health system?

How is screening for Medicaid eligibility assured?

How are medical services of multiple providers coordinated and monitored?

IV. Coordination/Linkages Among System Components

This is the second key component of the site visit. Questions in this section aim to describe how coordination of services is accomplished, the challenges presented by coordinating services, where families "fall through the cracks of the existing system, and how services needs and coordination needs change as families move through the system.

Two key links are: the coordination of housing and support services, and the coordination of education services for children with other support services. However, linkages and coordination are pertinent to all types of services delivery.

These questions will be addressed primarily to program staff.

A. Coordination Among Components

1. Coordination among funding programs
2. Coordination of eligibility

3. Coordination of record keeping
4. Coordination of intake/case planning
5. Coordination of service delivery

B. Links Between

1. Housing continuum and social services

- Funding (through coordinated housing and welfare benefits or through patchwork)
- Sanctions/incentives: Project Self-Sufficiency model or other model
- Service provider same or different from housing provider
- Coordination of eligibility criteria and program jurisdictions
- Duration of responsibility for family (through permanent housing, through welfare eligibility)

2. Education and social services

- Role in case management
- Role in supplemental socio-emotional and developmental services

3. Foster care system and homeless system

- Definition of environmental neglect
- Policy on mothers in treatment for substance use

V. Summary/Assessment

Questions in this section offer the respondent to provide additional information not otherwise solicited in the discussion. In particular, we are interested in general assessments of the strength and weaknesses of the system and philosophies of service to homeless people.

A. Overall, what would you cite as the major strengths and weaknesses of your city's system of services for homeless families?

B. What are the most important changes or improvements you would like to see implemented?

C. What other aspects of the service system for homeless families in your city should we address in this case study?

APPENDIX B

PARTICIPANTS IN PHONE DISCUSSIONS AND SITE VISIT INTERVIEWS

PARTICIPANTS IN PHONE DISCUSSIONS

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